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HEADLINE: Toward a national health plan - 1

KEYWORD: EDITORIAL SERIES US HEALTH CARE COST MEDICINE MEDICARE

BODY:

A groundswell is rising for a national health plan that would guarantee all Americans the means to obtain medical care at bearable costs. This is the classic idea whose time has come.

The base of support for such a plan has shifted; no longer is it limited to a socially conscious minority that seeks better medical care for the needy. The surge comes now from mainstream America, from middle-income workers whose health coverage is being lost as they lose jobs to the recession. And who, in the face of sky-high premiums, are asked to assume an ever larger share of the expense as employers scramble to cut their costs.

Americans now understand that premiums are so high - and going higher - because they are paying not only for their own care but also the medical bill for everyone with no coverage and little money. Uncollectible medical bills, so-called free care, wind up - as a hidden tax - in price increases for health insurance. This cost - and others - can be contained only by universal coverage. That is the telling point in support of a national plan.

Whether an entire health plan can be enacted this year remains uncertain only because of President Bush's staunch opposition, despite the rising demand for relief from health benefits by American business. There is no doubt that major reform in the way health care is paid for in the United States is coming soon - as it should. Even the staid American Medical Association now sees universal coverage as inevitable, right and necessary.

A political middle ground

Attention is being paid the health plans of Canada and Germany, which offer complete medical care at a lower cost than the United States, even though millions here lack coverage. Though bits of them appear in the one being crafted here, it is likely the US plan will be uniquely American, melding and broadening the private and government coverage that exists. Congress lacks the will to buy into a more efficient but foreign system.

A fistful of proposals have already been filed with Congress, and by early June the granddaddy of them all will be unveiled. This plan, still being worked on, has been forged over the past 18 months by four senators led by Sen. Edward Kennedy. At this time, the plan is named Americare.

It will be presented and championed by the Democratic leadership in Congress - in the Senate by Majority Leader George Mitchell of Maine and Sens.

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Kennedy, Jay Rockefeller of West Virginia and Donald Riegle of Michigan; in the House by Majority Leader Richard Gephardt of Missouri and Rep. Henry Waxman of California.

The Democrats have staked out a political middle ground that would keep the current mix of medical coverage, but fill in gaps that leave 90 million Americans with inadequate coverage or none. Rather than court defeat, the Democrats have veered away from the radically different, though cost-efficient, Canadian and German systems.

The plan would build on the two basic sources of coverage - public and private - that prevail in the United States. This clearly is the most politically and culturally acceptable route to go.

Drastically altering Medicaid

It would essentially preserve the huge government programs of Medicare for the elderly and Medicaid for the impoverished and nursing home patients. But it would shore up some of the soft spots in Medicare and drastically alter Medicaid.

Medicaid would be stripped of its demeaning status as a program for the poverty-stricken. It would be expanded to include the disabled, unemployed and working poor. Eligibilty and coverage would be made uniform in all 50 states, ending the stark and cruel differences from state to state. Adequate payment would also be required, replacing the low rates that discourage doctors, clinics and hospitals from accepting Medicaid patients.

In the private sector, the plan would insist that employers offer health insurance to all workers or contribute to a state pool that would obtain coverage for them under a new government-based program. The pool would be linked to a tax-subsidized federal fund to make health insurance affordable for small businesses and independent workers who have been shut out of coverage because of its high cost.

Americare also would require a decent level of coverage for everyone. The menu of benefits would include mental health and substance-abuse services as well as the customary medical, surgical and maternity care. Private plans would have common rates of payment to end competition based on cut-rate benefits.

Long-term care - in nursing homes and chronic-care centers - is not part of this initial plan. Instead, long-term care - which now costs $ 55 billion a year, primarily funded under Medicaid on a 50-50 federal-state basis - is being treated as a separate entity. A bill to deal with long-term care on a new set of terms is to be introduced by mid-summer, but it may be linked to Americare later.

Cost-containment provisions

Philosophic assumptions about cost containment permeate the plan. One is that the cost of health care is manageable only when everyone who can do so pays a fair share of the bill. Another is that cost shifting, the bane of the current system, can be eliminated only when everyone is covered and payment is appropriate and evenhanded. One more is the belief that cost can be controlled.

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Medical costs in the US have eluded every attempt to control them. In 1991, they will amount to $ 750 billion if research, construction, administrative costs and health-insurance profits are included - $ 571 billion if only the cost of personal health care is calculated. The US spends far more on health care than any other nation.

Nothing has worked, says medical economist Stuart Altman, acting president of Brandeis University. Instead, attempts to micro-manage the delivery of care have created layers of bureaucratic red tape that add billions to the cost. Hospitals and other medical-care providers have become expert at outsmarting cost-control regulators.

Encouragement of competition - the widely touted "business-market" approach - has produced nearly 2,000 health insurers, each with separate forms and administrative overhead, and each with a plethora of plans that vary in coverage and price. Health-claims processing has itself become a nightmare cost.

Competition has fostered cost shifting in myriad ways, such as the seeking of discount hospital rates by one company at the expense of others and the siphoning of healthy customers to private plans, while abandoning the chronically sick to government programs or the charity of hospitals, which transfer losses onto the bills of those with insurance - workers and employers.

As the Democratic leadership struggles to put the finishing touches on a national plan, the most difficult part has been the provisions for cost containment. Though not complete, the elements to be addressed have been decided upon. They would:

- Virtually eliminate cost shifting, now said to account for 25 percent of health-insurance premiums and for one-third of premium inflation.

- Reduce unnecessary care, by introducing guidelines derived from Medicare studies that identify overused procedures which fail to medically benefit patients.

- Minimize administrative costs in the private insurance market involving duplicative coverage, peer review, marketing and processing costs, and overhead. Minimize administrative costs in the delivery of health care by encouraging computerized record keeping and bill processing, and by simplifying and standardizing claims forms and payments under private and government coverage.

- Set a limit on overall health-care spending - a goal, a guideline or an outright cap. As a trade-off for the limit, health-care providers and hospitals would be released from considerable governmental red tape and paperwork. By permitting them more latitude on how best to spend the money budgeted for operations, the limit would exert pressure for prudence in purchasing expensive equipment and the use of costly medical technology.

Leaving room for choice

To overcome resistance by employers to any mandated job benefit, the Democrats' plan would leave open how much - within limits - employers and employees would pay toward health-insurance premiums. The plan would permit workers to pay a percentage of the premium costs but "no more than" a specified limit. Similarly, the plan would leave room for choice in terms of deductibles

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and co-payments to be paid by employees on medical bills. The intent is to leave room for traditional union and management negotiations while cultivating employer-employee cost sharing.

The United States cannot remain the only industrial democracy without a national health plan. The issue no longer centers on whether coverage for all Americans should be considered. It is how that coverage should be structured and how it will be paid for. Americans are ready to be shown.
NEXT: The politics of a national health plan.

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Health Care

SIMON INTRODUCES AMENDMENTS TO SENATE DEMOCRATIC HEALTH CARE BILL

WASHINGTON (BNA) -- Amendments to strengthen the cost-containment provisions, shorten the phase-in period, and lower the Medicare eligibility age were introduced by Sen. Paul Simon (D-Ill) in legislation to modify "HealthAmerica: Health Care Act of 1991" (S 1227), the Senate Democratic leadership's health care reform bill.

"I have applauded the efforts of my colleagues in introducing the HealthAmerica Act, but I have also been sensitive to some of the criticisms of the bill being made by those who see the need for stronger cost-containment and greater involvement of the health care consumer in development of national health care policy," Simon said in a statement announcing the amendment.

HealthAmerica would require employers to provide health insurance for employees or pay a payroll tax into a public insurance plan, AmeriCare.

Five Fundamental Changes

Simon's bill, "Improvements to the HealthAmerica Act of 1991" (S 1669), co-sponsored by Sen. Brock Adams (D-Wash), would make the following five fundamental changes to S 1227:

o strengthen the cost-containment program by making federal expenditure board determined rates mandatory if negotiators do not agree;

o make universal coverage take effect in slightly more than one year after enactment rather than a five-year phase-in period;

o allow states to opt out of the employment-based system if they adopt a single-payer, Canadian-style program, and provide authority for incentive grants for two states to implement such systems;

o give small businesses greater protection from possible discrimination against high-risk employees, strengthen their access to quality affordable policies, and provide them necessary consumer information on how to get the best insurance plan for their money; and

o lower the Medicare eligibility age to 60, subject to the enactment of revenue changes to support this modification.

Amendment Friendly To Small Businesses

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The amendments recommend several changes to address the health care problems facing small businesses, according to Simon. His bill would require insurers wishing to provide coverage to small businesses to provide both a basic and a comprehensive policy. To prevent small businesses from trying to sort through dozens of confusing policies, the Simon amendments also would require insurers to obtain approval from the Department of Health and Human Services to provide extra coverage.

In addition, the amendments would require HHS to publish a consumer guidebook on standard insurance policies to help businesses choose the policy best suited for them. It also would prevent insurers from tailoring their benefit packages to make them attractive only to the most healthy and risk-free employees.

"The reality is that we need major reform as quickly as possible and S 1227 is legislation that responds with improvements to our current crisis in health care in a way that many can support," Simon said. "My amendments move the HealthAmerica bill closer to the concept of a single-payer system."

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WHICH POLICIES ARE BEST?

If you lose your health-insurance coverage for any reason, you can remain uninsured and take your chances, or you can venture into the marketplace for an individual policy. Be forewarned: You won't find a buyer's market. And even if you're in good health, you may have few options.

This report will help guide you through the process. We evaluated 71 policies from 40 insurance companies and Blue Cross and Blue Shield organizations. We rate those policies and list their features beginning on page 546. Before plunking down $2000 or $3000 for coverage, however, you'll need to know a little about how these policies work.

Declining coverage
The proportion of employees in group health plans at large- and medium-sized firms dropped 14 percent from 1986 to 1988.

Types of policies

There are three basic kinds of health-insurance coverage:

☐ **Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.

☐ **Hospital-surgical policies.** These cover hospital services and surgical procedures only.

☐ **Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 539.

What's covered

Major-medical policies typically pay for most hospital services, including room and board; operating and recovery rooms; nursing care; and treatment in intensive-care units, emergency rooms, and outpatient facilities. They also pick up the tab for lab tests, X-rays, anesthesia, medical supplies, ambulance services, and physicians' office visits. Most pay for prescription drugs and cover confinements in skilled-nursing facilities, if necessary, following a hospital stay.

Some policies, however, don't pay for assistant surgeons or for standby surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

Hospital-surgical policies cover hospital room and board, often for a specified number of days; treatment in intensive-care and outpatient facilities; medical supplies; surgeon's fees; diagnostic tests relating to an operation; some radiation and chemotherapy; and sometimes second opinions. But they cover almost no expenses incurred outside a hospital. They won't pay for a doctor's office visit to check on a persistent cough, or to have your child's cast removed, or for any medical condition that does not require hospitalization. Most don't cover prescription drugs that you may need outside a hospital.

Generally, both major-medical and hospital-surgical policies pay for 30 days of inpatient treatment for mental illness and substance abuse. Some major-medical policies cover outpatient treatment as well. If they do, insurers limit the number of visits per year or even the dollar amount of their payments.

Maternity benefits

All the major-medical and hospital-surgical policies in our study pay for expenses arising from pregnancy complications. But with the exception of some Blue Cross and Blue Shield plans, they usually don't cover routine prenatal care or routine deliveries.

If you want coverage for that, you'll have to buy a separate rider, and at some companies, you'll need to decide on the rider the day you take out the policy. Some carriers won't let you buy the rider later (on the grounds that you'll probably use the coverage, and they'll be stuck with a claim). Many major-medical and hospital-surgical policies don't offer riders for routine maternity care, period.

Riders will pay up to a maximum benefit that policyholders select, usually $500, $1000, $2000, or $2500. Rarely do they cover the full cost of a normal delivery, which averaged $4334 in 1989.

Another drawback is that companies don't pay the full benefit during the first two years the policy is in force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

Annual premiums for pregnancy riders ranged from $316 at Golden Rule for a $1000 benefit to $2640 at Prudential for a benefit that would cover the hospital stay but only $1050 of an obstetrician's fee. (An obstetrician's services for prenatal care and delivery can cost as much as $4500 in some areas.)

What's not covered

Both major-medical and hospital-surgical policies cover only medically necessary care. Don't count on them to pay for routine physicals or other preventive services. (Some of them, however, cover Pap smears, mammograms, and well-child care.) Nor do companies pay for cosmetic surgery, fertility treatment, dental care, hearing aids, surgical treatment of obesity, treatment for self-inflicted injuries, or procedures that are considered experimental.

How policies pay

Insurance companies compute the amount of your reimbursement check according to their own complex formulas. The amount may be higher or lower depending on the following:

Eligible expenses. When you submit a bill for a service covered by a major-medical policy, the insurer compares it with the amount it normally pays for that service. If the charge is lower than what the company determines is "usual," "customary," "reasonable," or "common," then the entire bill is eligible for reimbursement. If it's greater, the carrier will consider only a portion of it.

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 90th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

hospital's posted charge, the hospital's cost, or a negotiated fee.)

Obviously, the higher the reimbursement standard, the more you'll receive. Unfortunately, policies don't spell that out, and some insurance companies were reluctant to explain their reimbursement standards to us.

Some hospital-surgical policies work differently, paying up to a maximum amount for each covered procedure or service listed in the policy. There's usually a fee schedule for hospital room and board, one for surgeon's fees, another for outpatient services, and a maximum amount the policy will pay for all other hospital services. This is the equivalent of a hospital-surgical policy's eligible charge.

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon who performs an appendectomy as little as $260 or as much as $480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was $846 for an appendectomy. The policy pays as little as $390 or as much as $720 for a hysterectomy; but a hysterectomy cost an average of $1737 in 1989.

Coinsurance. Once the insurer determines how much of your bill it will consider, it still pays only a portion. You pay the rest. That's called "coinsurance."

Most major-medical policies pay 80 percent of eligible expenses, leaving policyholders to pay the remaining 20 percent plus that part of the cost not covered at all.

Suppose a physician charges $3000 for an angioplasty (a cardiac procedure), but the carrier considers only $2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive $2088 (80 percent of $2610). He or she will then have to pay the remaining 20 percent, or $522, plus the $390 that's not eligible for reimbursement.

With some policies from Blue Cross and Blue Shield, a policyholder who used a "participating physician" would pay less. Participating physicians agree not to bill patients in excess of what Blue Cross and Blue Shield pays. This can be a significant advantage. Plans with this feature are noted in the Ratings.

Some major-medical policies require policyholders to pay less than the usual 20 percent coinsurance. For example, American Republic's *UltraCare* policy requires no coinsurance at all. Policies from Bankers Life and Casualty and its affiliated companies require none if policyholders select a deductible of at least $5000—that is, if the policy-

Pay by the Day? By the Disease?

THE WORST TYPES OF INSURANCE

The worst buys in health insurance are hospital-indemnity policies and dread-disease policies. Hospital-indemnity policies pay a fixed amount each day you're in the hospital. Dread-disease policies pay benefits only if you contract cancer or some other specified illness.

Such policies are a profitable staple for many well-known insurance companies and for the American Association of Retired Persons (AARP). They're sold to unsophisticated buyers through enticing but sometimes misleading advertising.

"Cash benefits of $2250 a month, $525 a week, $75 a day . . . You cannot be turned down . . . No salesman will call . . ." reads a flyer for a hospital-indemnity policy from Physicians Mutual. "Use these cash benefits any way you choose . . . Get extra benefits when you may need them most," promises an ad for a policy sold by the AARP.

The deal is simple and understandable. You get a fixed dollar amount for each day you spend in the hospital. No complicated deductibles or coinsurance. Trouble is, the fixed benefit is skimpy to start with and grows less valuable with each passing year.

At Physicians Mutual, a person can choose a daily benefit of $30, $50, or $75. AARP's top benefit is $75 for those age 50 to 64 and $45 for those 65 and older. But with the cost of a day in the hospital averaging around $800, even the most generous hospital-indemnity plans will barely dent your bill. Furthermore, to collect the high benefits touted by some of the ads, you'll need to be hospitalized as long as a month—an unlikely prospect, since the average stay is only about seven days. Finally, the benefit does not change. In time, inflation in hospital and medical costs inevitably shrinks its value.

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a $19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American Family Life, a large seller of this type of insurance, would pay a maximum of $4100; a policy from American Fidelity Assurance would cover as much as $6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

Companies also sell riders to cover such dread diseases as smallpox, polio, rabies, diphtheria, and typhoid fever. We don't know why anyone would buy them, since these diseases are now extremely rare.

Compared to other health coverages, these types of insurance are cheap. For the top daily benefit from Physicians Mutual, a 45-year-old man or woman would pay about $233 a year. A family would pay $540.

Insurers usually issue hospital-indemnity policies to anyone, whether or not they are in good health. But carriers often require a waiting period before covering policyholders for preexisting health conditions.

Most companies selling cancer insurance will not, however, issue policies to people who already have cancer. Nor do they usually pay benefits to anyone who is diagnosed as having the disease before the policy has been in force for 30 days.

These policies are no substitute for comprehensive health coverage. The price is low, but so are the benefits. With a dread-disease policy, you're also gambling that you'll contract one of the covered diseases. If you don't, the policy won't cover you.

Companies often market these policies as a supplement to other insurance. But we don't recommend them even for that. The $300, $400, or $500 you'd spend for inferior coverage may equal the difference in premium between a skimpy hospital-surgical policy and a more comprehensive major-medical policy. Or it may cover the cost of taking a lower deductible on a good major-medical policy.

holder pays the first $5000 of covered expenses.

Other companies require policyholders to pay more. You might find policies with a 70/30 percent or even a 50/50 percent cost-sharing arrangement, especially if you don't use doctors and hospitals specified by the insurer.

Coinsurance maximums. Most policies specify a maximum dollar amount of coinsurance, typically $1000 (but it can be as much as $2500 or $5000), that policyholders must pay annually. After they've reached that amount, the carrier pays 100 percent of all additional, eligible medical expenses.

A few policies tie coinsurance maximums to the size of the deductible you select. The higher the deductible, the lower the maximum.

Several policies give a break to families. Usually two members must each pay the maximum coinsurance amount. The company will then pay 100 percent of all eligible expenses for other members who have not reached their maximums.

Lifetime maximums. Most major-medical and hospital-surgical policies cap the benefits they'll pay over a lifetime at $1-million or sometimes $2-million. A few have no cap, and others have a separate lifetime maximum for each illness or injury.

A company will sometimes give new lifetime benefits to policyholders who have generated enough claims to reach their lifetime cap. This is an important feature if the cap is low.

Deductibles. Most companies require policyholders to satisfy deductibles each year before benefits are paid. (Some hospital-surgical policies have no deductibles.) Deductibles can be as low as $100 or as high as $20,000. That means a policyholder must pay the first $100 (or $20,000) of expenses before the company pays any benefits. Obviously, a $20,000 deductible buys only catastrophic protection.

Sometimes a policy links the deductible to an illness or health condition; you would have to satisfy the deductible with each new illness. If the deductible is large and you have several different illnesses, you may never collect any benefits.

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a $1000 deductible," says John Hartnedy, the chief actuary at Golden Rule. "You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill."

As with most insurance, the higher the deductible, the lower the premium. A 45-year-old man in Chicago who chooses a $500 deductible for Benefit Trust Life's *Tele-Med* policy would pay an annual premium of $1443. If he selected a $2500 deductible, he would pay only $839.

Sometimes, for a small, extra premium, companies will waive the deductible or a portion of it if you are injured in an accident.

Can you renew?

Few companies will guarantee to renew your coverage. Of those in our study, only American Republic, Benefit Trust Life, and Metropolitan sell "guaranteed renewable" policies. The company can raise the premium, but it must continue your coverage.

Most policies, however, are now "conditionally renewable." The company can refuse to renew your policy only if it also refuses to renew all other similar policies in your state. You have some protection because the company can't single you out for cancellation. But you can still lose your coverage.

Some insurance companies use conditionally renewable policies as a lever to force insurance regulators to grant the rate increases those companies want. Certified Life, First National Life, Golden Rule, and Washington National told us they had canceled policies. In some cases, they offered policyholders alternative coverage.

A few policies are "optionally renewable." A company can opt not to renew your insurance whether or not it renews coverage for others who have the same policy. Prudential, State Farm, and Blue Cross and Blue Shield plans in Illinois, Kansas, Ohio, and Oklahoma have optionally renewable policies. (Prudential and Blue Cross and Blue Shield of Oklahoma at least say they won't cancel your policy if your health has deteriorated.)

Many companies also give themselves the option of not renewing if they find you have another policy that is similar.

Are you insurable?

People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Virtually no commercial carriers and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

If you have less serious conditions, you may get coverage, but on unfavorable terms.

Conditions that usually affect one part of the body are candidates for "exclusion riders." That is, companies will offer a policy, but exclude coverage for those conditions or that body part, either for a short period or for as long as the policy is in force. If you have had a recent knee operation, glaucoma, migraine headaches, varicose veins, arthritis, a cesarean delivery, or if your child suffers from chronic ear infections, your policy will probably carry an exclusion rider. "Any condition that would produce an immediate claim would be ridered out," says Frank Fugiel, a vice president at Washington National.

If you have a medical condition that affects your general health—for example, you're significantly overweight or have mild high blood pressure—you may get coverage, but at a price 15 to 100 percent higher than the standard premium.

Companies in our survey told us that between one-quarter and one-half of all their policies carry exclusion riders, higher-than-standard premiums, or both.

Insurers, however, are not restrictive in identical ways. Washington National will exclude coverage for your eyes if you had a cataract operation a year ago. Prudential will not. If you suffered from migraine headaches in the past but have had no treatment for the last two years, Central States Health and Life will cover future treatment for such headaches; Time will issue a policy but exclude coverage for migraines.

If a company rejects you, that fact will be recorded at the Medical Information Bureau in Boston, an industry clearinghouse. The next time you apply for coverage, the new carrier may check your file at the bureau. If it finds you've been turned down, that rejection could trigger further scrutiny of your health.

Even if your health is perfect, you still may be a less-than-perfect risk. In their quest for applicants who are

Truth will out

When you fill out an application for health insurance, be honest about your medical condition. If you don't reveal all your health problems and the company finds out about them when you file a claim, it could rescind your policy and leave you without coverage when you need it most.

unlikely to file claims, insurance companies blackball people in certain occupations. Some companies have long lists of jobs that are unacceptable, either for an individual policy or for a policy sold to employees in small firms. Chances are the insurance company won't cover you if it considers your work hazardous or if people in your profession are more likely to file claims or switch jobs frequently.

Better off at the Blues?

Historically, most Blue Cross and Blue Shield plans took all comers for individual health insurance, offering "open-enrollment" policies that anyone could buy. Even if your health was bad, you could count on getting a policy from the Blues.

Today, only 22 of the 74 Blue Cross and Blue Shield plans in the U.S. still make policies available to everyone. But their "open-enrollment" policies may require policyholders to pay a larger portion of their expenses than policies offered to those in good health. For example, the open-enrollment major-medical plan sold by Empire Blue Cross Blue Shield in New York requires 20 percent coinsurance for all services. By contrast, its high-rated *Tradition Plus Wraparound* policy, sold only to those with no medical problems, requires no coinsurance on hospital services and also offers a much lower deductible.

Most Blue Cross and Blue Shield organizations now "underwrite." That is, they evaluate an applicant's health much the same way their commercial competitors do. They decline people with cancer and heart disease and sometimes issue policies with exclusion riders and higher premiums.

It's hard to say whether you'll have an easier time buying coverage from the Blues than from commercial insurers. Most of the Blue Cross plans we contacted refused to respond to our survey. Through other sources, we obtained the plans sold by uncooperative Blues and evaluated them along with the others.

Blue Cross plans that do not exclude health conditions or charge higher premiums for them may simply refuse to sell you a policy. On the other hand, a Blue Cross plan might be more lenient than a commercial insurer. Empire Blue Cross Blue Shield does not require blood tests to detect AIDS. Kentucky Blue Cross and Blue Shield insures women with fibrocystic breast disease. Commercial carriers often require blood tests and almost always exclude coverage for fibrocystic breasts.

Preexisting conditions

If you get a policy from Blue Cross and Blue Shield or a commercial insurer, you still may have to wait a year or two to be covered for medical conditions you already have.

Most policies say that a preexisting condition is one for which a policyholder has received treatment or for which a reasonably prudent person *should have sought* treatment during the previous two years. Some policies have shorter or longer "look-back" periods. Those are noted in the Ratings. *Continued*

The Last Resort

HIGH-RISK POOLS

If you can't buy health insurance and you live in one of 23 states listed below, your insurer of last resort is a high-risk pool created for the people insurance carriers don't want. Similar to the high-risk plans for drivers who've been in accidents, health-insurance pools originated in the 1970s as the industry's alternative to national health insurance. But only in the last few years have states begun to get serious about them.

To obtain coverage, you usually must be a state resident for at least six months (a year in some states), and must have received a rejection notice from at least one carrier (Montana and Florida require two rejections).

If a carrier will insure you only at a premium exceeding the price of coverage from the pool, or if the insurance you're offered carries exclusion riders, you will also be eligible for a pool policy in most states.

The rules differ from state to state. Illinois, Iowa, Minnesota, and Nebraska, for example, allow people infected with the HIV virus to obtain a pool policy; South Carolina does not. In some states you can't get pool coverage if you're eligible for a conversion policy when you leave an employer group, even though the pool policy may be better than the conversion option.

Florida, Illinois, Iowa, Minnesota, North Dakota, Tennessee, Washington, and Wisconsin make Medicare-supplement policies available through their pools. That's a boon to the disabled under age 65 who rely on Medicare but can't find insurance to fill Medicare's gaps.

Pool coverage is similar to that offered by a major-medical policy, although benefits for mental and nervous disorders, organ transplants, and pregnancy may be less comprehensive. You may, however, pay more out-of-pocket than you would with a major-medical policy. Some plans require a high deductible, greater coinsurance, and relatively low lifetime-benefit maximums—$500,000 or even $250,000.

Premiums are no bargain, which is not surprising since policyholders in the pool will almost certainly file claims. For example, a policy with a $500 deductible from the Illinois pool will cost a 45-year-old man living in Chicago $3844 a year. That's twice as much as he'd pay for the most expensive individual policy in our study available to Chicagoans.

Long waiting lists

Pool policies provide decent coverage, but they are available only to a fraction of those who need them. CU surveyed the pools last spring and found that they now cover only 55,500 people nationwide. Pools in Illinois, Maine, and Oregon currently limit the number they can insure. The Illinois pool can issue only 4500 policies. The wait to buy into the Illinois pool is now at least a year.

It's hard to see how the pools can meet even the existing need. They operate at a loss, despite the high premiums. In most states, losses are covered by assessments against all health-insurance carriers doing business in the state. In return, some states relieve insurers from part of their obligation to pay taxes on the premiums they collect.

But the insurance industry is pressing the states to pick up more of the bill from the public purse. "We're not in the business of giving away insurance at a loss to these people," says Carl Schramm, president of the Health Insurance Association of America.

The 23 states with high-risk pools are: California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Louisiana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. (The pools in California, Colorado, Georgia, Louisiana, Texas, Utah, and Wyoming are not fully operational.) Your state insurance department can tell you how to contact your state's pool.

To encourage applicants to reveal all their medical conditions, some companies waive their usual waiting periods *if* you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

The wrong job
Occupations some insurance companies consider unacceptable for health coverage:

Tree trimmers
Explosives handlers
House painters
Window cleaners
Heavy-equipment operators
Rodeo performers
Police officers
Doormen
Models
Freelance artists
Waiters
Masseurs
Hospital aides
Maids
Musicians
Bartenders
Fry cooks
Janitors
Street cleaners
Doctors
Lawyers
Pro athletes
Fishermen
Railroad workers
Test drivers
Car-wash workers
Dancers
Beauticians
Movers
Zoo attendants

What policies cost

The premiums you pay are based on your age, your sex, and where you live.

At Bankers Life and Casualty, a healthy 45-year-old man living in Chicago would pay $1245 a year; a 45-year-old woman, $1625; a 55-year-old man, $1748; and a 55-year-old woman, $1852.

The premium for a 40-year-old man, his 35-year-old wife, and two children would come to $3382.

A few Blue Cross plans still use "community rates," charging everyone the same premium regardless of their age or where they live. Other things being equal, older people are usually better off at a company using community rates. A 45-year-old man and a 60-year-old man living in Philadelphia would pay the same $2192 premium at Independence Blue Cross and Pennsylvania Blue Shield. But at Time, a company not using community rates, the 45-year-old man would pay only $1580; the 60-year-old, $3375.

With most policies, premiums increase as you get older. If you buy a policy at age 40, expect the premium to increase when you turn 45.

In addition to age-related increases, the rising cost of medical care also pushes up premiums every year or two. The premiums for policies in our study increased an average of 11 percent a year over the past five years. But premiums for some policies rose as much as 40 or 50 percent in a single year.

Pricing tricks

As a sales gimmick, some companies use a pricing scheme that gives policyholders a deceptively low premium the first year and very high premiums in later years.

When a company that uses so-called select and ultimate rates accepts you for coverage, it knows you're in good health and charges a low (select) premium to reflect the fact that you're not likely to file claims in the immediate future. But as the years go on, and as you make claims, the company will jack up the premium to the highest (ultimate) level.

Companies that don't use select and ultimate rates spread the anticipated costs of your claims over all the years you own the policy, so your premiums will be more stable. If you buy from a company using select and ultimate rates, you may face premium increases that far exceed what you can afford.

State insurance regulators don't require insurers to disclose whether they use select and ultimate rates, so it's often hard to know. It's a good idea, though, to ask whether a company you're considering uses such rates and to avoid their policies, especially if you plan to keep the coverage for several years. One carrier, Aid Association for Lutherans, gives buyers in some states a choice between policies with select and ultimate rates and those without, and clearly points out the differences in its sales material. (Our Ratings include Aid Association's policy without select and ultimate rates.)

Managed care and PPOs

Until recently, insurance companies seldom questioned physicians' fees. But to hold down their own costs, companies have now inserted a variety of "managed care" requirements into their policies.

As a result, you may have to ask the insurance company for prior approval for any elective surgery. You may have to use an outpatient facility for such procedures as arthroscopic surgery, dilation and curettage, and cataract removal. You may be required to seek second opinions before surgery. If you don't follow the rules, the company may reduce your benefit or increase the coinsurance and deductible you'll have to pay.

Some Blue Cross and Blue Shield plans offer Preferred Provider Organizations (PPOs). Those are groups of doctors who have agreed to discount their fees. If you sign up for a PPO and use a non-PPO doctor, you may have to pay as much as 40 or 50 percent of the doctor's bill yourself and also suffer other penalties.

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

A few other insurers also declined to participate. Celtic Life, a company waging a public campaign to educate people about shopping for health insurance, refused to shed any light on its policies or selling practices. A newcomer to health insurance, A.L. Williams, a company better known for its life-insurance policies, also declined to participate. A third company, World Insurance, claimed that if it won a favorable rating from CONSUMER REPORTS, it would not have the capacity to handle all the applications.

We rated the major-medical and hospital-surgical policies by measuring the coverage and cost-sharing features of each against actual claims, ranging from minor to catastrophic, filed by 25,000 employees. The average annual claims for a single person in the reference group totaled $1387; for families, it was $3175.

A policy that covers everything would pay 100 percent of those amounts. Of course, health-insurance policies are not designed to cover 100 percent of claims. But the best policies pay the most.

The best policy we found, a major-medical plan sold by Blue Cross and Blue Shield of Minnesota, would pay $1230 (or 89 percent) for singles and $2810 (or 89 percent) for families if you used physicians in the plan's preferred-provider organization. The worst, a hospital-surgical policy from Pyramid Life, would have paid only $490 (or 35 percent) for singles and $950 (or 30 percent) for families.

The Ratings show what percentage of the average annual claims each policy would pay after accounting for deductibles, coinsurance, coinsurance maximums, and other cost-sharing features spelled out in the contract.

Since most people want a policy that provides coverage for catastrophic expenses, we also measured how well each would pay for two major illnesses. One was a $19,774 claim for colon-cancer sur-

gery and follow-up chemotherapy. The other was a $49,767 claim for care of a serious heart attack, including an angioplasty procedure (see box on page 544).

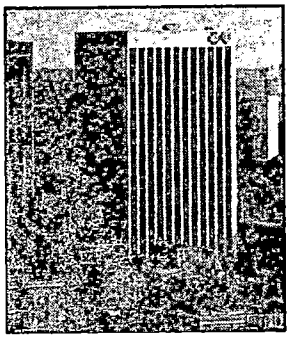
A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's lifetime benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

We could not obtain rate-increase histories or certain other information for noncooperative Blue Cross and Blue Shield plans or for new policies. Where we lacked information that might affect a plan's score,

Blue Cross and Blue Shield

ABANDONING THE MISSION



Sick people cannot buy a policy from Blue Cross and Blue Shield of Kentucky. The plan evaluates an applicant's health and rejects those with such afflictions as cancer, heart disease, emphysema, and AIDS.

Competition from commercial carriers has forced the plan to turn sick people away in order to keep its premiums affordable and attract new customers. At one time, Kentucky's Blue Cross and Blue Shield plan sold as much as 90 percent of all health insurance in the state. Today it sells just 30 percent.

The Kentucky plan, typical of many Blue Cross and Blue Shield organizations today, is a far cry from what such plans used to be. Founded by organized medicine in the 1930s, Blue Cross (and later Blue Shield) had two missions. The first was to make sure hospitals and doctors got paid. The second was to provide health insurance for the greatest number of people.

For years, the Blues had a virtual insurance monopoly. In some places, they were so powerful that they were able to negotiate large discounts from hospitals and use the savings to carry out their mission of community service. For example, Blue Cross plans subsidized such money-losers as individual health policies for the sick and Medicare-supplement coverage for the elderly.

As nonprofit organizations, the Blues had certain privileges. They paid no Federal income taxes and, in many states, no taxes on the premiums they collected.

"Community rating" was once the Blues' trademark. Everyone in the community—large employer groups, small employer groups, and individuals buying policies on their own—were in the same risk pool. They paid the same rates regardless of their age and sex, where they lived, or how sick they were.

That all began to change in the 1960s. Commercial insurers started skimming the best risks from the Blue Cross pool by offering lower premiums than the Blues charged. As large groups and then small ones took out cheaper policies with commercial carriers, the Blues increasingly found themselves covering people with health problems the commercial carriers didn't want. As healthy people deserted the pool, the Blues had little choice but to raise premiums higher and higher to cover the claims made by the sick people who remained.

In many areas, the plans also saw their hospital discounts whittled away. Some states now mandate smaller discounts and allow all insurers to receive them.

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned community rating a few years ago in favor of the kind of pricing used by its commercial competitors.

Most Blue Cross and Blue Shield plans now resemble Kentucky's. Many have become mutual insurance companies. They've lost their tax exemption from the Federal government, and they no longer try to provide coverage for everyone. Less than one-third still take all comers for health insurance. Of the 37 state regulators responding to a CU survey, only nine consider their local Blue Cross and Blue Shield plan an insurer of last resort.

"We think the Blues in our state do a pretty good job. But everyone here dislikes them, from their subscribers to the legislators," says one state insurance regulator who asked not to be identified. "They are some of the most defensive people you can imagine. Everything we ask for is a fight."

We know what he means. We asked 29 Blue plans to send us information about their policies. Only nine would do so, forcing us to seek information from state regulators, who sometimes couldn't or wouldn't help us. The California Insurance Department told us it had no rates on file for Blue Cross of California. When we asked the plan for a history of its rate increases, an official told us that information was "proprietary." When we asked the Washington Insurance Department to give us rate-increase data for the Washington and Alaska plan, the department said it could not oblige because Blue Cross had a right in that state to keep such information a secret.

"As their risk pool gets creamed, there's mission schizophrenia at the Blues," says Susan Sherry, an official at Families USA, a health-advocacy group. "It's the classic example of competition, and consumers are the real losers."

Some Blue Cross and Blue Shield plans, mostly in the Northeast, still cling to the old mission. But even for them, holding on is increasingly difficult.

In New York, a person no matter how sick can always get health insurance from Empire Blue Cross Blue Shield. It won't be the top-of-the-line policy, but it will provide some coverage.

Empire, which still uses community rates, can sell insurance even to people with terminal illnesses because their policies are heavily subsidized from premiums paid by large employer groups and from the savings obtained by negotiating a 13 percent discount with New York hospitals.

Even so, Empire officials say that the discount is not large enough, and that over the last few years some 100,000 people have left the pool, either going with commercial carriers or doing without coverage altogether. The plan has had to increase premiums on all its policies 40 to 50 percent to cover the claims of the sick people who remain.

"Our goal is to stay with the mission," says Eric Schlesinger, Empire's chief marketing officer. "But in the end, we will have a community price so high that no one will pay it, and the number of uninsured will skyrocket."

we assigned values representing the average for all plans in our survey. This lack of actual information for a plan is denoted by a dash in the Ratings. The plans are listed in order of an overall quality index that takes into account all the rating factors.

Recommendations

Naturally, you want a policy that will pay as many of your bills as possible, so coverage should be your first concern.

Unfortunately, there are few policies for any one individual to choose from. Your options boil down to a policy from one of the few remaining commercial carriers selling this insurance or one from your local Blue Cross and Blue Shield plan.

The best coverage is provided by a good major-medical plan. The plans listed high in the Ratings require policyholders to pay very few of their medical expenses.

A number of Blue plans—in Minnesota, New Jersey, New York, and Pennsylvania—ranked high. People in those states should certainly consider them. As the Ratings show, however, Blue Cross and Blue Shield organizations in other states offer mediocre or poor policies.

Fortunately, some good commercial plans are widely available. Look first at the high-rated policies offered by American Republic and Benefit Trust Life.

Maternity benefits from some of the Blues were better than those offered by most commercial carriers. Many Blue plans treat pregnancy as an illness and pay normal benefits, which will cover most of the cost of having a baby. But some offer maternity benefits only on family policies. Presumably a single woman who became pregnant would not have coverage.

Some Blue Cross and Blue Shield plans offer a choice of a regular insurance policy and a PPO. You might consider a PPO if you're willing to use its doctors rather than your own. The PPOs offered by Blue Cross and Blue Shield in Arizona, Illinois, Minnesota, and Washington and by Blue Shield of California ranked higher in our Ratings than those organizations' traditional insurance plans because they require their subscribers to pay less coinsurance.

Policies from First National and Washington National provide good benefits for catastrophic expenses but fall short in other important areas, such as policy cancellations or rate increases.

Note that the policy from the largest seller of individual major-medical insurance, Golden Rule, ranks near the bottom. The policy provides only average coverage. And the company has a history of large rate increases and canceled policies.

Once you have considered a policy's coverage and other dimensions, look at the premium. If two policies are comparable, pick the one with the lowest premium.

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay $806 a year for a hospital-surgical plan, compared with $1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

The highest room-and-board coverage offered by the hospital-surgical policy from Blue Cross and Blue Shield of Maine, for example, is $276. Some of the state's hospitals have room-and-board charges that exceed $400.

Hospital-surgical plans provide fewer benefits, and those benefits may not increase with the cost of medical care. Unless the carrier lets you upgrade, the benefits you buy today may be inadequate if you need hospital care several years from now.

If you can't swing the premiums for a high-rated major-medical policy, consider reducing the premium with a higher deductible, then budget to cover small medical expenses yourself.

If you're not in perfect health, it's hard to buy coverage at any price. It may nevertheless be worthwhile to shop several carriers to see if they'll issue coverage with exclusion riders.

If you live in Alabama, Hawaii, Maryland, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, or the District of Columbia, you will be able to buy an "open-enrollment" policy from Blue Cross and Blue Shield at least sometime during the year.

In Maine, the Blue Cross and Blue Shield organization accepts anyone for coverage, but will add exclusion riders for three years on policies for people with various health conditions.

If you live in one of 23 states with a high-risk pool, you may be able to purchase coverage from the pool.

There's no insurer of last resort for people living in the other 15 states. Short of getting a job with a large business or marrying someone who works for one, people who are unacceptable to insurance companies are out of luck. They have no choice under the current system but to join the growing ranks of the uninsured.

Ratings begin on page 546

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Catastrophic Claims

PERCENTAGE GAMES

As part of our evaluation of health-insurance policies for the accompanying report, we measured how much each policy would help defray the actual bills run up by two patients in apparent good health who were suddenly stricken with a life-threatening illness—colon cancer and heart attack.

The case of colon cancer cost a total of $19,774, including $13,471 in hospital bills and $3665 for surgery.

The best plan we found, from Blue Cross and Blue Shield of Minnesota, would have paid about 92 percent of the $19,774 if the policyholder used only "preferred provider" doctors. (If the policyholder went to other physicians, the plan would pay up to 88 percent.) The highest-rated policy from a commercial carrier, American Republic's *UltraCare* with no coinsurance, would have paid 97 percent. A less generous major-medical plan, from Washington National, would have paid 87 percent of the claim. Least helpful was a hospital-surgical policy from Pyramid Life. It would have paid only 49 percent of the bill, leaving the patient about $10,000 in debt.

The treatment for the heart-attack patient came to $49,767. It included an angioplasty (a procedure to open blocked arteries) that cost $8730 in surgical fees, and a 21-day hospital stay that piled up bills of $34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the $49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a $28,000 debt as well as the heart attack.

WHEN YOU LEAVE A GROUP PLAN

If you leave a job, you may have two options for continuing your health insurance short of shopping for an individual policy on your own. Depending on the size of the firm you worked for and on your state's insurance regulations, you may be able to continue your group coverage for a short time as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Or you may be able to obtain an individual policy through a process known as conversion. Both options, though, will usually cost a lot more than you would spend for group coverage.

Because it is less expensive and generally offers better coverage than a conversion policy, your first line of defense should be COBRA.

COBRA: How it works

If you worked for a business with 20 or more employees, COBRA entitles you and your dependents to continued coverage for at least 18 months under your former employer's plan. If you are disabled and eligible for Social Security disability benefits when your employment ends, you can obtain an additional 11 months of coverage, for a total of 29 months.

If you are insured through your spouse's plan at work and your spouse dies, you become divorced or separated, or your spouse becomes eligible for Medicare, COBRA provides for coverage of up to 36 months.

COBRA requires that you pay 102 percent of your group insurance premium. If your employer has been paying a portion, you will have to assume that cost in addition to what you were already paying, plus an extra 2 percent for administrative costs. Disabled people who take COBRA coverage must pay as much as 150 percent of the premium for the extra 11 months.

You can lose coverage if you don't pay the premiums, if you become eligible for Medicare, if your employer discontinues health insurance for employees still working there, or if you join another plan.

However, if you join another plan and have an existing medical condition for which that plan imposes a waiting period, you can still keep your COBRA benefits until they would normally run out. By that time, your preexisting condition may be covered under the new plan. But you could be without coverage for that condition if your COBRA benefits stop before the waiting period on the new policy is over.

If you work for a company that has self-insured its workers' health coverage, you are entitled to COBRA benefits, even though such plans are normally exempt from other insurance regulations.

If you are not eligible for COBRA because your former firm employs fewer than 20 workers (or is a church organization), you may still have some protection under state laws. If your state provides for "continuation" of benefits, you may be able to stay on your employer's group policy for as little as three months in some states or as long as 18 months in others. (Those benefits are usually not available to workers in self-insured plans.)

The following states do *not* have comprehensive continuation laws: Alabama, Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Pennsylvania, Wisconsin, and Wyoming.

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

After COBRA coverage runs out, or if you're not eligible for it, your next options are to take a conversion policy or shop for individual coverage. (Unless, of course, you're covered under a new employer's health plan or become eligible for Medicare.)

The law requires that every employer who normally offers conversion policies to workers who leave also offer them to former employees once their COBRA benefits run out. Fifteen states, as well as the District of Columbia, don't require employers to offer conversion policies to employees who leave. They are: Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, and Oklahoma.

If an insurance company terminates a group plan, employees may also be out of luck. Two-thirds of the states require insurers that cancel group policies to offer conversion options to people losing their coverage.

Even when it is offered, conversion coverage is almost always inferior to what you received from your group plan. (Twenty-four states require companies to offer conversion policies with major-medical or comprehensive benefits.) If you currently have major-medical coverage, a conversion policy may provide only hospital-surgical benefits and only pay up to a fixed amount each day for hospital room and board and surgical procedures (see page 538).

For example, CIGNA, an insurer that offers several conversion options to employees converting from the group policies it underwrites, pays only $250 for hospital room and board if an employee chooses its top-of-the-line conversion coverage. For employees in a top-of-the-line group policy, CIGNA would pay most of the hospital charge, which runs considerably more than $250. (The average cost of a day in the hospital is about $800.)

While benefits are low, the prices of conversion policies are high, reflecting the fact that it is mostly people in poor health who buy this coverage. CIGNA, for example, charges a 45-year-old man or woman living in Chicago an annual premium of $4736 for its most generous conversion policy with a $500 deductible. By comparison, American Republic, the top-ranked commercial company in our study, would charge a 45-year-old man in Chicago $1904; a 45-year-old woman, $2240.

Despite those drawbacks, a conversion policy may be your only option if you have health problems. (Insurers must make these policies available to anyone regardless of their health.)

If only one member of your family suffers from some medical condition, you may want to take the conversion policy for him or her and try to find cheaper, individual coverage for the rest of the family. In some states, a person with health problems may be eligible for coverage from the high-risk pool, although in certain states, if you're eligible for a conversion policy, you can't have pool coverage.

If you're considering buying an individual policy instead of taking your conversion option when COBRA coverage ends, do your shopping well in advance. The slightest health problem can disqualify you, and it may take time for an insurer to collect your medical records and decide if it's willing to issue coverage. Once your COBRA benefits run out, you have only 31 days in most states to sign up for a conversion policy.

RATINGS

Health-insurance policies

Listed by types. Within types, listed in order of estimated overall quality, based on policies for a single person. (Family policies closely tracked single policies in overall quality.) Differences of less than 5 points were judged insignificant. Companies marked with an asterisk did not respond to our survey. Dashes indicate we could not obtain information; in those cases we assigned values representing the average for all policies.

1 Annual premiums. These are annual premiums for 45-year-old **men** and **women** living in Chicago. For a company not selling there, the premium is for the company's major operating territory. **Family** premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with $500 deductibles. If the company does not offer a $500 deductible, we show the premium for the closest deductible to $500; footnotes (on pages 548-549) state the deductible on which the price is based. Premiums for **maternity rider** show the cost of adding coverage for routine pregnancies.

2 Quality index. A summary of how the policy performed for a **single** person.

3 Payout. The percentage the policy paid for a **single** person and for a **family** on an average mix of claims filed by 25,000 policyholders. We used a $1000 coinsurance maximum for each policy. If the policy did not offer this amount, we used its maximum that was closest to $1000. Most plans require 20 percent coinsurance. Exceptions are noted in the Comments.

4 Catastrophic claims. Measures how well a policy would have paid after the deductible was met on two actual claims involving catastrophic illness—one for treatment of colon cancer; the other, a serious heart attack. A policy that scored a ● paid more than 96 percent of the expenses for both claims. A policy with a ◓ paid more

	Policy	1 Annual premiums: Men	Women	Family	Mr	2 Quality index	3 Payout	4 Catastrophic claims
Major-medical								
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	$1493 [1] [2]	$1962 [1] [2]	$5100 [1] [2]		Excellent	Included	●
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 [3]	1815 [3]	3923 [3]		Excellent	Included	●
American Republic	UltraCare, no coinsurance	1904 [4]	2240 [4]	5012 [4]		Excellent	$608	●
Blue Cross and Blue Shield of New Jersey	Medallion	1843 [2] [5]	1843 [2] [5]	4759 [2] [5]		Excellent	Included	●
Benefit Trust Life	MMI	1794 [6]	2096 [6]	4319 [6]		Excellent	Included	●
Empire Blue Cross Blue Shield	Tradition Plus Wraparound (LGL 3252)	2392 [7]	2392 [7]	6126 [7]		Excellent	Included	●
Independence Blue Cross w/Penn. Blue Shield	Major Medical w/Plan 100	2192 [10]	2192 [10]	5159 [10]		Excellent	Included	●
Blue Cross and Blue Shield of Minnesota	Aware Care (F2239)	658 [2]	882 [2]	2226 [2]		Excellent	Included	◓
American Republic	UltraComp	1632 [2]	1953 [2]	4333 [2]		Excellent	636	◓
American Republic	UltraCare, 20% coinsurance	1596 [4]	1877 [4]	4200 [4]		Excellent	608	◓
Blue Cross of Washington and Alaska*	Personal Prudent Buyer, Low Option 200, Wash.	1092 [2] [8]	1092 [2] [8]	2376 [2] [8]		Excellent	None	◓
Blue Cross and Blue Shield of Alabama*	ALPHA Plan	1308 [2] [9] [10]	1308 [2] [9] [10]	3432 [2] [9] [10]		Excellent	72	◓
Blue Cross and Blue Shield of Illinois*	Non-Group PPO	1543	1932	4363		Excellent	261	◓
Blue Cross and Blue Shield of Montana*	Personal Choice Plan	1851	1851	4241		Excellent	Included	◓
Blue Cross and Blue Shield of Montana*	Healthy Montanan Plan	1553	1553	3554		Excellent	Included	◓
Blue Cross and Blue Shield of New Jersey	Direct Payment Supplemental Major Medical	3167 [10]	3167 [10]	6135 [10]		Excellent	Included	◓
Blue Cross and Blue Shield of Indiana*	Personal Security	1293	1374	2935		Excellent	1164	◓
Blue Cross and Blue Shield of Oklahoma*	Health Check	1764 [11]	1764 [11]	3780 [11]		Excellent	Included	◓
Blue Cross and Blue Shield of Maryland*	Personal Comp	1001	1001	2604		Excellent	Included	◓
Central States Health & Life	Individual Major Medical (569-570, 571-572)	1463 [2]	1900 [2]	3721 [2]		Excellent	781	◓
Time	24 Karat (502)	1580 [2]	1876 [2]	3854 [2]		Excellent	490	◓
Benefit Trust Life	Tele-Med	1443	1822	3878		Excellent	1257	◓
Bankers Life and Casualty	VIP V (CR-G002)	1245 [2]	1625 [2]	3382 [2]		Excellent	None	◓
Bankers Multiple Line	The Spectrum Plan (D-G002)	1245 [2]	1625 [2]	3382 [2]		Excellent	None	◓
Union Bankers	The Spectrum Plan (MM-89)	1245 [2]	1625 [2]	3382 [2]		Excellent	None	◓
Blue Shield of California*	Preferred	1952	1952	3299		Excellent	None	◓
Blue Cross and Blue Shield of New Jersey	Blue Care	1261 [2]	1261 [2]	3400 [2]		Excellent	Included	◓
Blue Cross of Washington and Alaska*	Traditional Individual in Alaska	1933	1933	4123		Excellent	None	◓
Blue Cross of California*	Personal Prudent Buyer	1680	1680	3888		Excellent	3360	◓
Blue Cross and Blue Shield of Illinois*	Non-Group Comprehensive	1838 [13]	1992 [13]	4886 [13]		Excellent	None	◓
Blue Cross and Blue Shield of Maine	Blue Alliance	1294 [15]	1294 [15]	2580 [15]		Excellent	Included	◓
Empire Blue Cross Blue Shield	Tradition Plus Comprehensive (LGL 3253)	1507 [14]	1507 [14]	3228 [14]		Excellent	Included	◓
Benefit Trust Life	MM2	1496	1751	3603		Excellent	None	◓
Blue Cross and Blue Shield of Arizona*	Preferred Care	716	716	1928		Excellent	None	◓
Aid Association for Lutherans	TotalMed II (4945)	1708 [2]	1724 [2]	4032 [2]		Excellent	1860	◓

Better ◀—▶ Worse

than 90 percent. A policy with a ○ paid at least 81 percent, and a policy with a ◒ paid at least 75 percent of the expenses.

5 Lifetime maximum. Total benefits a policy will pay over a policyholder's life.

6 Maternity coverage. This shows the quality of the maternity rider that covers routine pregnancies and deliveries. If a policy offered coverage for complications only if policyholders buy a rider for routine coverage, it scored a ●. It scored a ◒ if it offered coverage for complications without requiring purchase of the rider.

7 Renewability. Guaranteed means the policy is guaranteed renewable for the policyholder's life. **Conditional** means that the company can cancel it along with all similar policies. **Optional** means the company can cancel an individual policy.

8 Rate history. A ◉ indicates that over a five-year period the company has raised rates on the policy less than the medical consumer price index, which averaged 7.2 percent each year over the period. A ◒ means that it raised rates at least 17 percent a year.

9 Preexisting illness. The **waiting period** is the number of **months** a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for disclosed illnesses. The **look-back period** is how far back in time the insurance company will investigate for preexisting illness.

10 Available to anyone. A "yes" indicates the policy is available to any applicant regardless of health status.

11 Exclusion riders. A "yes" indicates the company will issue coverage with exclusions for certain conditions or for certain parts of the body.

12 Higher rates. A "yes" means the company will issue coverage but at higher premiums for some medical conditions.

13 Other coverage. Additional coverages and features a policy may offer. See Key.

	3 Payout						9 Preexisting illness								
2 Quality index	Single	Family	4 Catastrophic claims	5 Lifetime maximum	6 Maternity coverage	7 Renewability	8 Rate history	Waiting period, mo.	Look-back period, mo.	10 Available to anyone	11 Exclusion riders	12 Higher rates	13 Other coverage	Comments	Telephone
85	89%	89%	◉	None	◉	Conditional	◉	24	3	No	Yes	Yes	a,b,c	A	800-382-2000
83	84	87	◉	None for basic policy	◉	Conditional	◒	12	12	Yes	No	No	a,c,d	C	717-255-0820
81	82	68	◉	$1-million per condition	○	Guaranteed	◉	24	24	No	Yes	Yes	a,d	B	800-247-2190
80	88	88	◉	None	◉	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500
80	86	85	○	1-million	◉	Guaranteed	◉	24	24	No	Yes	Yes	a	C,G	708-615-1500
80	83	82	◉	1-million	◉	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757
80	83	83	◉	None for basic policy	◉	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100
79	76	72	◉	None	◒	Conditional	◉	24	3	No	Yes	Yes	a,c,h	—	800-382-2000
78	74	60	◉	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190
77	75	61	◉	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190
75	82	67	—	1-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663
75	75	60	—	None for hospital	○	Conditional	◉	12	24	No	Yes	No	a	J	800-392-5705
75	73	61	—	1-million	◒	Optional	◉	12	12	No	No	No	a,c,h	E	312-938-7209
74	68	62	—	None	◉	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
74	68	62	—	None	◉	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
74	74	74	◉	None for basic policy	◉	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500
74	82	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075
74	77	72	—	1-million	◉	Optional	◉	12	6	No	Yes	No	a,c,h	K	918-560-2121
74	73	72	—	1-million	◉	Conditional	◒	9	No limit	No	Yes	No	a,c,d	—	800-992-2308
73	73	60	◉	1-million	○	Conditional	◉	12	24	No	Yes	Yes	a	—	402-397-1111
73	72	60	◒	2-million	○	Conditional	◉	24	12	No	Yes	Yes	a	—	800-333-1203
72	71	58	◒	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	312-777-7000
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	312-777-7000
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	214-939-0821
71	73	60	—	2-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150
71	70	70	◒	100,000 per year	◉	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500
71	75	60	—	1-million	◒	Conditional	◒	12	12	No	Yes	No	a	—	800-752-6663
71	68	55	—	2-million	◒	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-6000
71	70	56	—	1-million	◒	Optional	◉	12	12	No	No	No	a	—	312-938-7209
70	67	72	—	None for basic policy	◒	Conditional	◉	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966
70	61	59	◉	500,000	◉	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757
69	72	60	○	1-million	◒	Guaranteed	◉	24	24	No	Yes	Yes	a	C,G	708-615-1500
69	75	62	—	1-million	◒	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	800-543-2944
69	71	60	◒	2-million	○	Conditional	◉	24	No limit	No	Yes	Yes	a,d	—	414-734-5721

Ratings
Continued

	Policy	Annual premiums: Men	Women	Family	Maternity rider
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 928	$ 987	$2108	$1164
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 12	2044 12	4359 12	Included
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 12	1169 12	2454 12	Included
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2085	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1208	1208	2653	Included
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Included
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 14	2042 14	4030 14	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 2	1748 2	3382 2	None
First National Life	Major Medical (MM-286)	1005 16	1137 16	2142 16	748
Blue Shield of California*	Coronet	2941 14	2941 14	4229 14	None
Pyramid Life	G91	1501 2	1863 2	4015 2	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3623	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 14	940 14	1814 14	None
Prudential	Pru-Med (PM-83)	1228 2 14 17	1584 2 14 17	3127 2 14 17	2640
Washington National	Classic Choice (AM2836)	1764 2	2205 2	3249 2	900
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 18	1579 18	3451 18	Included
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 18	1968 18	4729 18	Included
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 19	2004 19	3742 19	Included
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 18	1250 18	2472 18	Included
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 20	1216 20	2966 20	Included
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 9	756 9	1848 9	Included
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 18	1162 18	2846 18	None
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 18	1033 18	2058 18	Included
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 8	814 8	1844 8	Included
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 18	1266 18	2683 18	515
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 18	1336 18	2796 18	Included
Blue Cross and Blue Shield of New Jersey	Co-pp Protection Plan and Series 14/20	1992 18	1992 18	3439 18	Included
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	806 2	1043 2	2137 2	None
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 2	1043 2	2137 2	None
Union Bankers	Major Hospital Surgical (HS-89)	806 2	1043 2	2137 2	None
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 4	853 4	2177 4	None
Certified Life	Hospital Surgical Protection (CER-G020)	806 2	1043 2	2137 2	None
Pyramid Life	G95	1016 2 10	1250 2 10	2472 2 10	645
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 18	839 18	1886 18	Included

1 *$500 deductible on hospital services only.*
2 *Rates for nonsmokers.*
3 *$350 deductible on nonhospital only.*
4 *$500 deductible for each condition every 3 years.*
5 *$300 deductible only for supplies and drugs.*
6 *$250 for nonhospital services.*
7 *$300 deductible.*
8 *$200 deductible.*
9 *$200 deductible for each hospital admission.*
10 *$500 deductible on nonhospital only.*
11 *$400 deductible.*
12 *$750 deductible.*
13 *$300 deductible for each hospital admission; $500 for all services.*
14 *$1000 deductible.*
15 *$200 deductible for nonhospital services.*
16 *Atlanta rates; $500 deductible for each condition.*
17 *$100 deductible for hospital inpatient stays only; $1000 for other services.*
18 *No deductible required.*
19 *$250 deductible.*
20 *$60 deductible for each hospital admission.*

Key to Other Coverages
a–Prescription drugs for home use.
b–Preventive care for all ages.
c–Participating physicians for all families.
d–Mammography.
e–Pap smears.

			3 Payout					9 Preexisting illness									
Quality index	Single	Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mo.	Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage	Comments	Telephone
2			4	5	6	7	8			10	11	12	13		
69	74%	60%	—	$1-million	○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075
68	66	65	—	1-million	●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164
68	66	65	—	1-million	●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164
68	70	62	—	1-million	◒	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600
68	74	61	—	1-million	◒	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663
67	70	58	◓	1-million	○	Conditional	◓	12	No limit	No	Yes	No	a	—	800-868-2500
67	70	67	—	1-million	●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622
67	71	68	—	1-million	●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011
65	62	51	◓	1-million	○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211
64	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
64	65	53	●	1-million	○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850
63	65	53	—	2-million	◒	Conditional	◒	12	12	No	Yes	No	a,c,d	—	800-624-5150
63	72	60	◓	2-million	○	Conditional	◒	24	24	No	Yes	Yes	a,d,e	—	913-722-1110
62	74	60	●	1-million	○	Conditional	◒	12	24	No	Yes	No	a	—	817-297-4123
61	62	51	—	1-million	◒	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944
61	63	55	○	None	○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642
61	71	59	◓	2-million	○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500
81	77	80	●	None	●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820
77	76	77	●	None	●	Conditional	○	12	12	Yes	No	No	c	C	215-564-2100
76	70	70	—	None	◓	Conditional	◓	6	6	Yes	No	No	c	B,L	313-225-8000
76	76	75	—	None	●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200
71	63	66	—	None	●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200
70	71	75	—	500,000	●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797
68	58	50	◓	none	◒	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211
67	55	53	—	none	◓	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3536
67	59	59	—	1-million	◓	Conditional	—	12	12	No	No	No	c	F	406-444-8210
66	62	66	—	1-million	●	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	216-687-7218
62	65	67	○	None	●	Conditional	◒	12	12	No	No	No	f	B,H	201-822-4500
61	63	66	○	None	●	Conditional	◒	12	12	Yes	No	No	f	C,H	201-822-4500
58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
58	52	45	◓	None	◒	Conditonal	◓	24	24	No	Yes	Yes	—	—	312-777-7000
58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
53	55	45	◓	1-million	◒	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311
50	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
42	35	30	●	2-million	○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110
67	68	72	◒	None	●	Conditional	●	11	24	Yes	No	No	d	B	212-490-4757

f–Participating physicians for families below some income levels.
g–$50/year for preventive care per person.
h–Well-child care.
i–Major-medical coverage after $2500 deductible is met.
j–Major-medical coverage after $25,000 of covered expenses are incurred.

Key to Comments

A–Coinsurance on hospital and $10 copayments for physicians' visits.
B–No coinsurance.
C–Coinsurance only for certain services.
D–Less coinsurance after the first year.
E–If PPO doctors not used, coinsurance and coinsurance maximums are higher.
F–30 percent coinsurance.
G–Pays a set amount for hospital room and board.
H–Surgical-fee schedule.
I–Pays set amount for all services for each day in the hospital.
J–Routine maternity rider offered only with family policies.
K–Routine maternity coverage is included as part of policy only with family policies.
L–Maternity coverage only for delivery and hospital stays—no doctor visits covered.
M–Routine maternity coverage and coverage for maternity complications offered only with family policies.
N–No maternity coverage even for complications unless rider is purchased.

William Raspberry

Health Care Giveaway

The reason for America's health care crisis, Pat Rooney insists, is not that medical care *costs* too much but that we *spend* too much on it.

The focus on the cost of medical care, he says, leads to proposals for imposing limits on what doctors and hospitals can charge, which medical procedures can be authorized (and by whom) and other attempts to put a lid on medical bills.

Rooney, who is head of the Golden Rule Insurance Co., says it's possible to bring down employer-subsidized health care *spending*—perhaps even bring it down dramatically—without tinkering with the cost of individual medical procedures.

He'd do it by giving the individual worker an incentive to forgo unnecessary medical treatment and to shop for the best value in cases where treatment is necessary. Here's the proposal:

"Give each worker an allowance for medical care that represents, say, two-thirds of the [per capita] money the employer is now spending for health care. Tell them that any of that money they don't spend on health care is theirs to keep—permanently. Then buy them an umbrella insurance plan for the really big medical bills that might come up: costs like injury from a bad auto accident or heart bypass surgery or the premature birth of a child.

"Then watch the cost of medical care drop."

Rooney, who was in Washington (from Indianapolis) last week to pitch his idea to staff of the Office of Management and Budget, offered an example of how it could work.

An employer making annual premium payments of $4,500 per employee family (the national average for medium-size cities) would, under Rooney's scheme, put $3,000 into each employee's medical care bank account and let the employee pay the first $3,000 of his own medical bills.

The remaining $1,500 of the employer's contribution would be used to purchase an umbrella group policy that would pay 100 percent of medical costs after the first $3,000. (Two-thirds of all medical spending at present is under $3,000 per family.)

It's a little like a deductible auto insurance policy, except the employer provides the money for the deductible amount.

But here's where the scheme gets interesting. Any of the $3,000 that doesn't get spent on medical bills belongs to the employee. If, for example, he has no medical costs for three years running, he winds up with $9,000 *to do with as he pleases*—whether to buy a car, make the down-payment on a house or finance a European vacation—with no tax liability until the money is withdrawn for some non-medical use.

The relevant point is that it would have the effect of containing medical care spending, now rising at the rate of some 17 percent a year—in part because there is little incentive for individual policyholders to keep the costs down.

To see why this is so, Rooney suggests, imagine that employers issued grocery credit cards that paid 80 percent of an employee's food bill after a $100 deductible and 100 percent after the first $5,000. His prediction: "Grocery stores would stock only the highest-priced food because that is all the employees would want to buy. Why? Because they'd be spending someone else's money. And that is why we spend so much on medical care in the United States.

There are other details, less exciting but no less vital to the economic and political viability of Rooney's proposal. Since it would involve changing the tax code (to permit employees to pay their doctor bills with untaxed cash and also to accumulate tax-free savings), provisions would have to be made for employees whose companies did not offer the plan, or for people temporarily out of work.

As clever as the Rooney proposal looks (Rooney says he borrowed major chunks of it from others) it looks even better when compared to the "play or pay" idea being advocated in Congress. Under that idea, employers (including small and marginally profitable companies) would either "play" by buying health insurance for their employees or else "pay" with an 8 percent payroll tax to cover the cost of Medicaid. The consequences, says Rooney, would include unemployment (as some employers simply couldn't afford the extra costs) and a mushrooming Medicaid, as more and more employers found it cheaper to "pay" than "play." But Medicaid pays only about half a physician's normal charges—a tolerable arrangement as long as only a tenth of the patients are on Medicaid. But what happens when the Medicaid proportion grows? Will more and more doctors refuse to take Medicaid patients—as many already do?

Rooney acknowledges that his proposal could have one unfortunate side-effect: Some people would be so seduced by the prospect of an employer-provided bank account that they'd forgo needed medical attention in order, say, to buy a car.

Says Rooney: "So? I have a car. Don't you? Why should we deny anyone else the right to make that choice?"

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Hurdle for Preventive Medicine: Insurance

BYLINE: By ELISABETH ROSENTHAL

BODY:

At a time when physicians are increasingly likely to recommend preventive health measures from mammograms to cholesterol checks, patients are often faced with the discovery that insurers will not pay the bills.

Although the effectiveness of screening and counseling has now been proved in many areas, the insurance industry is still taking its first tentative steps in the field.

''One of the major dilemmas of a doctor trying to incorporate preventive services into practice is the payment issue,'' said Dr. Robert Lawrence, chairman of the Division of Primary Care at the Harvard Medical School. ''It costs nothing for a physician to order a mammogram, but if the patient is stuck with a large out-of-pocket expense, she won't come back for the next one.''

Private health insurers generally do not cover preventive medical services: immunizations, counseling about smoking and weight loss, and screening tests like mammography to detect silent disease. The chief reasons private insurance companies give are the difficulty of pricing services like counseling; the fact that insurers see their role as covering costs of disease, not routine health care, and the rising cost of insurance to consumers as more patients seek screening tests.

'A Ludicrous Conspiracy'

Medicare, the Government insurance program for the elderly and disabled, is prohibited by law from paying for preventive measures other than those specifically mentioned in the Medicare Act. The only one currently covered for all elderly is the vaccine against pneumococcal pneumonia; PAP smears to screen for cervical and uterine cancer will be added on July 1.

With such erratic coverage, experts say most preventive care in this country is financed by what one called ''a ludicrous conspiracy'' between doctors and patients. ''On the requisition the physician puts down 'breast lump' or 'rule out cancer,' and then the onus is on the third-party payer,'' Dr. Lawrence said. ''You have to perjure your record routinely to do right for your patient.''

Insurers defend their circumspection, saying that reimbursing a patient for a mammogram is akin to paying a car owner for an oil check. ''The traditional nature of insurance - car insurance, homeowner's insurance - is to pay for

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unpredicted events,'' said Stan Carson, director of the Center for Corporate Public Involvement, a branch of the Health Insurance Association of America and the American Council of Life Insurance. ''Prevention is not that. Traditionalists still say we shouldn't cover it.''

But now, driven by consumer pressures and legislative arm-twisting, many insurers are rethinking that position.

Uncertainty Over Economics

To attract health-conscious customers, a very few insurance companies now offer modified plans that will cover screening tests for a slightly higher premium. ''Any time we provide new services, that raises the cost,'' said Mr. Carson, who thinks insurers should move into the prevention field. ''We're still trying to figure out the economics.''

In the last two years more than half the states have enacted legislation requiring insurers to reimburse patients for routine mammograms, which generally cost more than $100, as part of new or renewed policies. Several bills pending in Congress would add the test to Medicare as well.

One in 10 American women will get breast cancer, and early detection through mammography and physician examinations dramatically enhances the chance of a cure.

The current pressure on insurers springs in large part from a new legitimacy enjoyed by preventive medicine. In 1984 the Federal Government recruited dozens of health experts to form the United States Preventive Services Task Force and charged it with surveying the rapidly accumulating literature on hundreds of preventive measures.

The panel's final report, issued last summer, endorsed a complex schedule of periodic PAP smears and mammograms, regular blood pressure and cholesterol checks, vaccinations for the elderly and counseling.

''The task force report was a significant milestone for preventive medicine,'' said Dr. Gordon De Friese, director of the Health Services Research Center at the University of North Carolina, a member of the panel.

But traditional health insurance provides little for outwardly healthy adults and critics say this focus allows avoidable conditions to flourish and kill.

'A Terrible Shame'

''It's a terrible shame that the two big guns of cancer screening, mammography and sigmoidoscopy, are often not covered,'' said Dr. Daniel Miller, director of the Strang Clinic in New York, who has tried to interest insurers in early cancer detection for a decade. For example, sigmoidoscopy, inspection of the lower colon with a lighted tube, can find precancerous lesions or early cancer when no symptoms are apparent.

Representative Mary Rose Oakar, an Ohio Democrat who has championed the cause of mammography, complains that insurance pays for strokes caused by high blood pressure but not for routine blood pressure checks; for cocaine addicted babies, but not drug treatment for pregnant women. ''Our national strategy is

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painfully remiss,'' she said. ''We do it all backwards.''

Experts say health maintenance organizations (H.M.O.'s), which market full service care under one roof for a set fee, are the only places where patients regularly obtain preventive services as part of normal coverage. A growing number of preferred provider organizations, in which patients obtain discounted care by visiting only the group's pool of doctors, are also marketing prevention. But many consumers avoid these ''pre-paid'' plans because of the restrictions they impose.

For traditional insurers, who reimburse by ascribing a dollar value to each service, prevention poses thorny problems. ''Insurers have a hard time figuring out how to pay for the fuzzy things we feel are so important, like counseling,'' Dr. De Friese said. ''They're much more enthusiastic about immunizations, which have a beginning and an end.'' The Preventive Services Task Force report recommends that doctors periodically advise patients on numerous subjects, from seat belts to exercise to smoking cessation.

Using Business Judgment

Another source of reluctance is cost. ''Insurance companies have to be actuarially responsible and when they do estimates, it is not always clear that this is a good business proposition,'' Dr. De Friese said.

Although preventive efforts avert serious diseases and their costly consequences, the saving is often offset by dramatic rises in use of those services. More patients visit the doctor and, thanks to a heightened level of awareness, there is more diligent following up on problems that are unearthed. ''Prevention may still be a sensible investment, but what it offers is lives, not a solution to the medical cost problem,'' said Dr. Louise Russell, an economist at Rutgers University and an expert in the field.

Both private and governmental insurers are making fledgling efforts to pay, but coverage is often patchy. Since state legislatures moved in to force the issue two years ago, many insurers now cover mammograms.

In 1988, the Blue Cross and Blue Shield Association of America issued guidelines for covering preventive services to its 74 member organizations. To date, less than a quarter of the plans are known to offer preventive coverage, almost always by hooking clients into affiliated prepaid plans.

Mammograms for Under $50

In the public sector, the short-lived Medicare Catastrophic Health Care Act, which was repealed last year, included coverage of periodic mammograms for up to $50. Congress is now scrutinizing several bills to allow some payment for the test. A small number of radiologists offer screening mammograms for under $50, since they are simpler than those done to evaluate suspected cancers.

For the poor, the biggest share of prevention dollars disbursed through Medicaid are reserved for children. Even cholesterol and blood pressure testing are not covered for healthy adults.

Both government and private insurers have pilot projects under way to determine the effectiveness and costs of covering prevention.

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Insurance professionals seem startled by the push to take on the new preventive role. And if there is blame to be laid for their initially sluggish response, they say it must be shared with the companies that buy insurance for employees. ''It's not as if the insurance industry is standing with its arms folded saying 'no!' '' Mr. Carson said. ''We respond to the market and if employers tell us they want preventive coverage, it'll be there.''

CORRECTION-DATE: April 20, 1990, Friday, Late Edition - Final

CORRECTION:

A chart on the Health page yesterday about preventive health procedures misstated the recommended frequency of mammograms to detect breast cancer for women over 50. It is one to two years, not every two years.

GRAPHIC: Table showing who covers preventive procedures

SUBJECT: MEDICINE AND HEALTH; PREVENTIVE MEDICINE; TESTS AND TESTING; IMMUNIZATION AND IMMUNITY; HEALTH INSURANCE

NAME: ROSENTHAL, ELISABETH

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July 5, 1990, Thursday, Late Edition - Final

SECTION: Section A; Page 1, Column 1; National Desk

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HEADLINE: HEALTH: Cheating on Insurance;
Insurers Say Growing Fraud In Health Care Costs Billions

BYLINE: By ELISABETH ROSENTHAL

BODY:

Most of the expectant couples who turned up for the delivery orientation at a hospital in Southern California two years ago were thrilled when an administrator told them, over coffee and doughnuts, that the hospital would offer a discount on their care.

Although most insurance contracts require patients to pay 20 percent of medical fees, the hospital planned to accept the 80 percent insurance reimbursement and then charge the patients for only a portion of the remaining bill.

But one prospective father was not happy with the arrangement - Ronald Lang, an insurance fraud investigator. He recognized the tempting offer as a practice known as ''waiver of co-payment,'' which insurers say bilks them of revenue by, in effect, overstating actual fees.

''I'm usually a quiet guy, but I was really angry,'' Mr. Lang recalled in an interview. ''I stood up and said, 'Are you aware that this could be considered fraud and of what you are doing to the cost of health insurance in this country?' Everyone was booing. Even my wife told me to just sit down.''

A Growing National Practice

For these couples, the hospital's plan probably seemed like a boon and a just reward for their rising insurance premiums. To insurers like Mr. Lang, who works for the Principal Financial Group, based in Des Moines, it was yet another vivid demonstration that health insurance fraud has become something of a national practice. And now insurers are beginning to fight back.

Insurance companies estimate that private and government insurers paid $60 billion last year for claims that were fraudulent or abusive, payments they say increase the cost of insurance for everyone. This spending amounts to 10 percent of the $600 billion national health care budget.

Some of this money paid for useful medical care that was simply not covered by insurance policies. But insurers say they should not have to pay for care they have not contracted to provide.

Members of the Health Insurance Association of America, an industry group, investigated 19,600 cases of fraud last year, an increase of almost 60 percent since 1987. The increase, they say, reflects both more fraud and intensified

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detection efforts.

'The Tip of the Iceberg'

James L. Garcia, director of the health insurance tracking unit at the Aetna Life Insurance Company, said there was evidence that 3 percent of the nation's doctors routinely committed outright fraud.

''But what we know about is probably the tip of the iceberg,'' he added. ''It is awfully difficult to detect since our main source of information is the patient, who often doesn't recognize the billing as fraudulent and who will approach his doctor first if there are questions.''

Some of the fraudulent acts are obvi-ous thievery, like surgeons' billing for operations they never performed. But some are common billing practices in which doctors and patients are willing co-conspirators. For example, a doctor may list ''cough'' rather than ''smoking cessation'' as the purpose of an office visit so the patient's insurance company will pay, or falsify the date on which a service was performed so that it will fall within a policy's coverage dates.

''Insurance fraud is on the rise, and filling out insurance forms has become an area of intense gamesmanship,'' said R. James Guzzi, chairman of the insurance industry's National Health Care Anti-Fraud Association, who is an executive at the Travelers Companies. ''To the degree that patients go along with it, we all end up paying.''

In the last five years insurance companies have initiated ambitious campaigns to ferret out offenders, complete with computerized fraud detection systems and toll free telephone lines for patients to report their doctors' transgressions. They concede that it has been difficult.

''Many patients feel: 'Why are you harassing my doctor? He's just trying to be nice to me,' '' said Dr. Mark Lachs, a Yale University internist who is studying health insurance fraud. ''There's really a spectrum of activity from well-intentioned actions to outright fraud.''

And doctors bristle at the scrutiny. ''Insurers have adopted a junior G-man approach,'' said Dr. Lonnie Bristow, a board member of the American Medical Association. ''Physicians attempt to act with honor and integrity in the best interest of their patients. That insurers suggest other motives is a despicable cheap shot. I don't know of any doctor who had engaged in insurance fraud, although I am sure there must be one somewhere.''

The Diagnosis
Naming Ailments To Fit the Rules

Many doctors acknowledge that minor deception is commonplace. It is sometimes necessary, they say, to squeeze money out of tight-fisted insurers who too frequently balk at paying for recommended treatment, including preventive services.

''If a patient needs a mammogram to screen for cancer, you put 'breast lump' on the form,'' said Dr. Robert Lawrence, an advocate of preventive health care who is chairman of the department of medicine at Cambridge Hospital in Massachusetts. ''You're forced to perjure your record to do right for your

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patient.''

A physician from Kansas who spoke on the condition of anonymity called it ''a game.'' He said: ''You know the guidelines; you have to have one symptom from Column A and two physical findings from Column B to have a prostate operation approved. So if I think a patient needs the surgery, I make sure those things are mentioned in my chart, and the paperwork sails through.''

But insurers say fraudulent practices are often used not to benefit the patient, but as a business ploy. Weight-loss and smoking clinics that advertise ''most insurance covers'' are immediately suspicious to insurers, Mr. Garcia said, adding: ''In most cases, insurance doesn't cover these things. We often find they fabricate a diagnosis, like high blood pressure.''

Mr. Guzzi of the National Health Care Anti-Fraud Association estimates that besides outright fraud, up to 25 percent of physicians may engage in practices that are abusive, although not technically fraudulent: scheduling visits that are of limited benefit, for example. Or an ear, nose and throat specialist might charge for a complete exam and then add a charge for looking down the throat with a mirror.

Patients who agree to have insurance checks sent directly to their health providers may not see or scrutinize insurance statements.

The Bill
When 'Forgiveness' Is Marketing

Among the many fraudulent and abusive practices condemned by insurers, forgiveness of co-payment has become the most controversial.

Most private insurance policies, as well as Medicare, require a patient to pay part of his medical bill, usually 20 percent. Although only 14 percent of the cases investigated by the Aetna fraud unit last year involved forgiveness, insurers suspect the practice is often unreported and probably epidemic. In a poll commissioned by Aetna in 1989, 23 percent of the respondents said their doctors had waived a co-payment in the last year.

Insurers are disturbed by the practice not only because it is a breach of contract, but also because they rely heavily on co-payments as a device to curtail casual or unnecessary medical visits.

''I understand why they're worried,' said Dr. Lachs, the Yale internist. A patient who has a mildly annoying condition like bunions might seek treatment in a clinic that advertised ''free services,'' using the forgiveness of co-insurance, he said. ''Here, the crime is not victimless: the forgiveness led to over-utilization, and premiums will reflect that.''

In addition, insurers say that money lost by waiving co-payment is often recouped by claiming higher rates. ''You know and I know that the hospital doesn't really just absorb the 20 percent loss,'' said Jan Meisels, deputy director of the Health Insurance Association of America. ''Those revenues will be gained in some other way and other bills will be inflated.''

Studies of California dentists have shown that those who routinely forgive co-payments set their base fees 25 percent higher than other dentists and

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perform dramatically more elective procedures, like full mouth X-rays and crowns.

Action by Legislatures

Insurers insist that if a physician intends to forgive a co-payment he is ethically, and perhaps legally, required to report that fact on the claim form he submits; the insurer would then reimburse 80 percent of the discounted fee. For example, if an office visit officially cost $100, the insurance company would consider the true fee $80 and reimburse $64.

At least a few state legislatures as well as several health organizations agree. In Colorado, any health professional who waives co-payment in more than 25 percent of cases or who advertises ''free medical care for patients with insurance'' is subject to criminal prosecution. This year the Florida Department of Insurance declared that any health provider who had agreed to forgive co-payment before rendering care had to report that fact or be liable to legal action.

After some major debates in the mid-1980's, the American Dental Association now considers undisclosed forgiveness of co-payment to be ''overbilling'' and an ''ethical impropriety'' that may be cause for revoking a license.

But organized medicine defends the practice. ''If a doctor chooses to forgive a co-payment, that's between him and his patient,'' said Dr. Bristow, the A.M.A. board member. ''It's an age-old principle of medicine for physicians to consider a patient's ability to pay to reduce or forgive charges.''

In California, legislation regulating forgiveness of co-payment has been blocked by medical societies and hospital groups, Ms. Meisels said.

The Motives
From Innocuous To Outright Sinful

Dr. Lachs said his studies showed that doctors' motives in committing fraud range from saintly to sinful. ''As a doctor, I had previously considered something like forgiveness to be an innocuous billing practice that well-intentioned providers used to benefit indigent patients, and sometimes this is true,'' he said in a recent interview. ''But the practices are also being used regularly to defraud insurers and as a marketing technique.''

Experts say potentially fraudulent billing practices designed to insulate patients from medical charges are particularly rampant in areas where there is an oversupply of doctors or where prepaid plans like health maintenance organizations have squeezed traditional private practitioners. Patients covered through these arrangements receive free or discounted care by agreeing to visit only doctors and hospitals designated by the insurers; health care providers who do not take part often find that their business suffers.

A hospital in Florida is challenging that state's new prohibitions on forgiveness of co-payment, contending that it is a legitimate discounting plan. But experts worry that in an age of ''creative'' billing, physicians who play by the rules will be placed at a competitive disadvantage.

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Dr. Lachs said that as insurers crack down on fraud, they would be wise to consider the motivation for the crime. ''They shouldn't be going after the family practitioner who forgives co-payment for an old lady who can't afford her medicine if she pays the bill,'' he said, adding that if they did, she might end up in the hospital at the insurers' expense because she could not buy her medicine.

The Response
Finding the Guilty: A Major Challenge

Although doctors are skeptical, insurers say they are not interested in prosecuting the Robin Hoods of medicine who occasionally fiddle with the system for a poor patient's benefit. Instead, they want the physicians who routinely falsify claims to increase their profits.

But finding the guilty parties has proved a major challenge. In addition to special telephone lines, insurance companies are using computers to scrutinize piles of claims for patterns that suggest foul play. The system identifies claims submitted for care on dates that were weekend days or holidays, or notes a large number of bills from a doctor on a single day.

Even so, patients remain crucial -and reluctant - informers. ''Fraud probably often goes unreported,'' Dr. Lachs said, ''because the bond between the patient and his doctor is stronger than that between the patient and his insurer.''

Insurers express frustration over their efforts to get offenders punished. Only five states have specific laws dealing with false claims in health care that subject practitioners to civil and in some cases criminal prosecution; generally, these prohibit advertising fraudulent practices rather than the practices themselves. The states are Connecticut, Massachusetts, Michigan, Ohio and Washington.

Health care providers may also be tried under mail fraud laws, since false claims are transmitted through the mail.

''It's difficult to get these cases prosecuted,'' said Mr. Garcia, the Aetna official. ''It's a white-collar crime, and prosecutors don't take them on because the dollar loss in each individual case does not meet their minimum requirement.''

Last year 323 health providers were convicted in cases involving private insurance fraud, and 138 for fraudulent activities involving Medicaid and Medicare, a number that has grown with each succeeding year, said Richard Kusserow, inspector general of the Department of Health and Human Services, who is responsible for uncovering fraud in the Medicare and Medicaid systems.

Dr. Lachs said: ''Right now there's no good data on the breadth of the problem. To me the million-dollar question is, What percentage of the care is delivered under benevolent and what percentage under malevolent pretexts?''
Aetna Life & Casualtyd(Aetna Life Insurance)

GRAPHIC: Photos: James L. Garcia of Aetna Life Insurance Company says there is evidence that 3 percent of doctors are routinely committing fraud (Steve Miller for The New York Times); Dr. Mark Lachs, researching improper claims, finds that doctors' motives range from good intentions to outright fraud. (Bill Burkhart

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for The New York Times); graph showing the percentages of the various types of fraud on insurance claims (source: Health Insurance Association of America) (pg. B7)

TYPE: A special report.

SUBJECT: MEDICINE AND HEALTH; SURVEYS AND SERIES; HEALTH INSURANCE; FRAUDS AND SWINDLING; DOCTORS

NAME: ROSENTHAL, ELISABETH

GEOGRAPHIC: UNITED STATES

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PAUL CRAIG ROBERTS

National's health's risky side effects

The Democrats are gearing up to ruin health care for all of us for the sake of a minority who are uninsured. True to form, the Republicans will respond by supporting a less costly version of socialized medicine.

The problem with national health insurance is that it puts medicine on the federal budget where it must compete with organized interest groups for its share of spending against Social Security, education, government pension benefits, agricultural subsidies and everything else.

Initially, the results may seem to be an improvement in the distribution of health care, but soon budget pressures and unlimited demand for care force medical benefits to be rationed. The ultimate effect is to stifle the private provision of health care and to reduce the proportion of GNP spent on health.

To contain health costs and to distribute health care more evenly are the two motives driving the push for a national health plan. Invariably as experience has shown, national health systems contain costs by skimping on the latest medical technology and equipment and by creating long waiting lines for access to expensive operations and long-term hospital care.

Uniform pricing standards lower the quality of medical care by subsidizing mediocre health care providers at the expense of more competent doctors. The net effect for the majority will be to reduce the access to health care along with its quality in order to improve the access for a minority. This definition of fairness is arbitrary and has no special ethical basis. National health systems also make the doctor-patient relationship more impersonal and bureaucratic. Rationing does not allow a patient to choose his or her doctor or even to have the same one. Doctors never get to know their patients, and patients never get to know their doctors. Consequently, health care suffers.

The idealism that often accompanies the initiation of a national health service soon dissipates as everyone's frustrations mount. If private practice is still permitted, those who can afford it soon desert the state system, leaving less articulate and influential patients at the mercy of bureaucratic medicine. Thus, accountability declines. Anytime accountability declines, malpractice rises. The budgetary pressures from rising malpractice expenses will force government to limit malpractice claims and leave patients more exposed to substandard health care.

There will always be those who will argue that substandard care for all is better than no care for some. This same claim can be made for everything — housing, clothing and education. It is not impossible to organize society around the lowest common denominator. Generally, that is what happens when private responsibilities are socialized. The 20th century has been dominated by big government ideology, and every conceivable scheme has been tried. Where can we point to any success? What has government made work better? The answers to these questions make powerful arguments against turning our health over to the government's care.

Private insurance and Medicare have sharply driven up the cost of medicine. When the costs are shifted to third parties (insurance companies and the government), neither consumers nor providers of health care have any incentive to contain costs.

The sharp rise in health care costs that has resulted from these efforts to expand coverage has reduced the access of the poor to health care. Providers can no longer afford the charitable services that they once made available. Unless steps are taken to restore elements of individual responsibility for health care, costs are destined to rise while standards decline.

Paul Craig Roberts, an economist at the Center for Strategic and International Studies, is a columnist for The Washington Times.

WTimes 10/16/91 P. F1

NEWS YOU CAN USE

Coverage denied

Your treatment was expensive. Now comes the battle over the bill

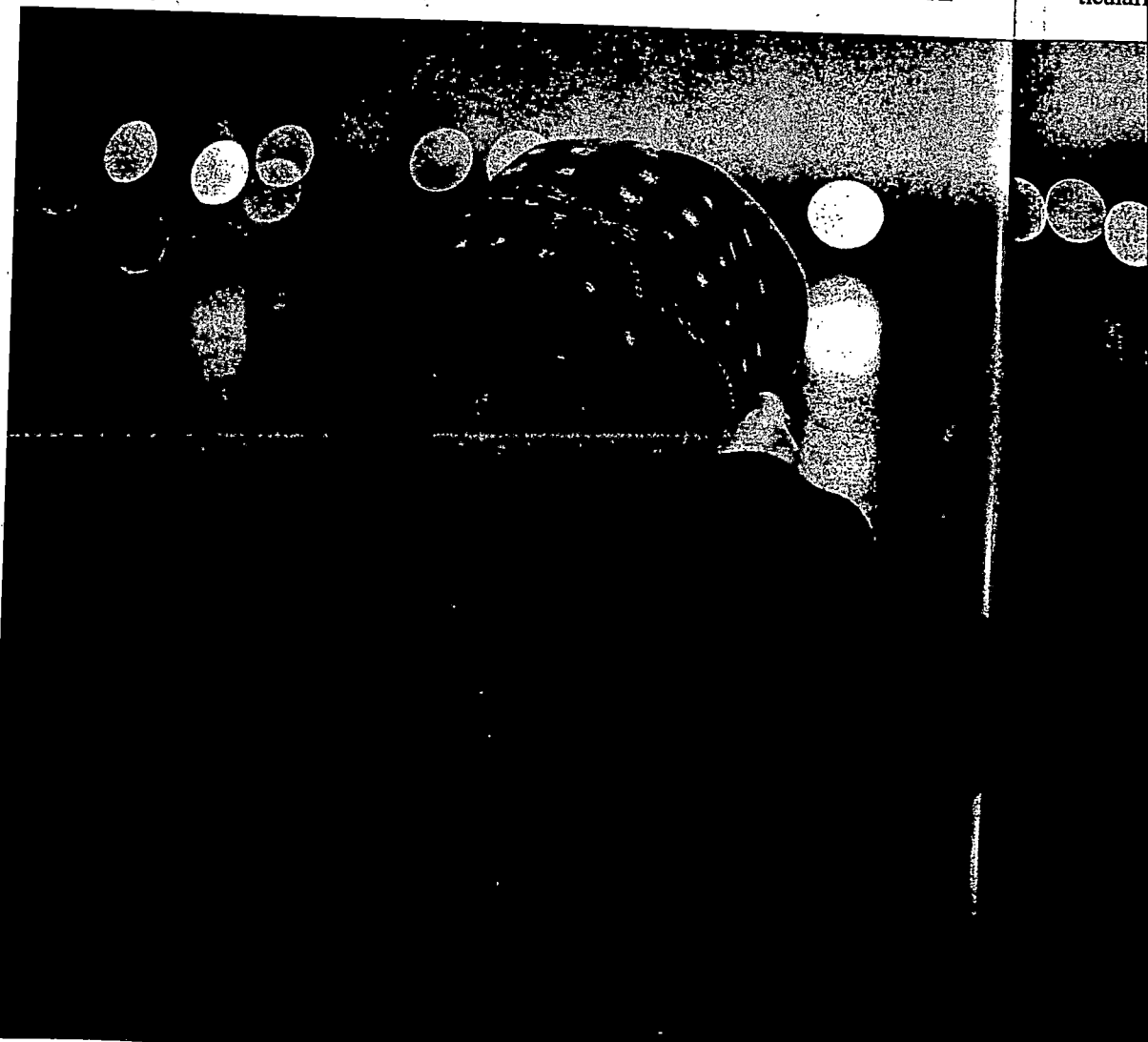
For 20 years, Lorraine Hiskey's twice-monthly migraine bouts so immobilized her that she could do little else, she says, but "wait for the pain." Then last year, fed up with taking one painkiller after another to no avail, she let experts at the Michigan Head-Pain and Neurological Institute in Ann Arbor try a new approach. The doctors hospitalized Hiskey for eight days and gave her intravenous infusions of the antimigraine drug dihydroergotamine, which constricts the blood vessels in the head. The treatment worked: In the past year, the 55-year-old Arlington, Va., resident has had only three migraine headaches. But her battle is far from over. Hiskey's insurer, Blue Cross/Blue Shield of Virginia, has refused to pay her $6,500 medical bill, claiming her treatment was "experimental" and thus not covered.

Although presidential candidates and Capitol Hill pols have focused attention lately on the 35 million Americans who have no health coverage, insurance companies are also drawing increasing fire for stingily refusing to cover some expenses for the majority of Americans enrolled in private health plans. In the name of "managed care" and "utilization review"—buzzwords for the way insurers monitor the procedures doctors perform—insurers and employers routinely deny coverage for medical care deemed experimental, unproven, unnecessary or inappropriate.

The trend affects everyone from migraine sufferers like Hiskey to heart and cancer patients. A recent Gallup survey of 200 cancer doctors, for example, revealed that 1 in 8 of their patients did not get the doctor's preferred treatment because insurers refused to pay. In another survey, 220 of 289 cancer doctors polled said that insurance denials had increased in 1990 over past years. "Insurers are using the experimental label more and more as an excuse not to pay for well-accepted treatments," says Lee Mortenson, executive director of the Association of Community Cancer Centers in Rockville, Md. "Patients are suffering because of it."

Trimming costs. Insurers say they are only trying to protect patients from unnecessary medicine and improve the overall quality of care. Indeed, most experts agree that between 15 and 25 percent of medical care *is* inappropriate or unnecessary or uses technology not yet proven effective. But that's only half the tale. The primary aim of most insurers is to trim costs. "If we paid for everything, premiums would go through the roof," says John Cova, director of medical technology assessment at the Health Insurance Association of America.

Consumers caught in the middle of the health-care coverage struggle are beginning to fight back—and win. Al-



Fighter. *Brenda Miller sued her insurer after it wouldn't pay for her breast-cancer treatment, which*

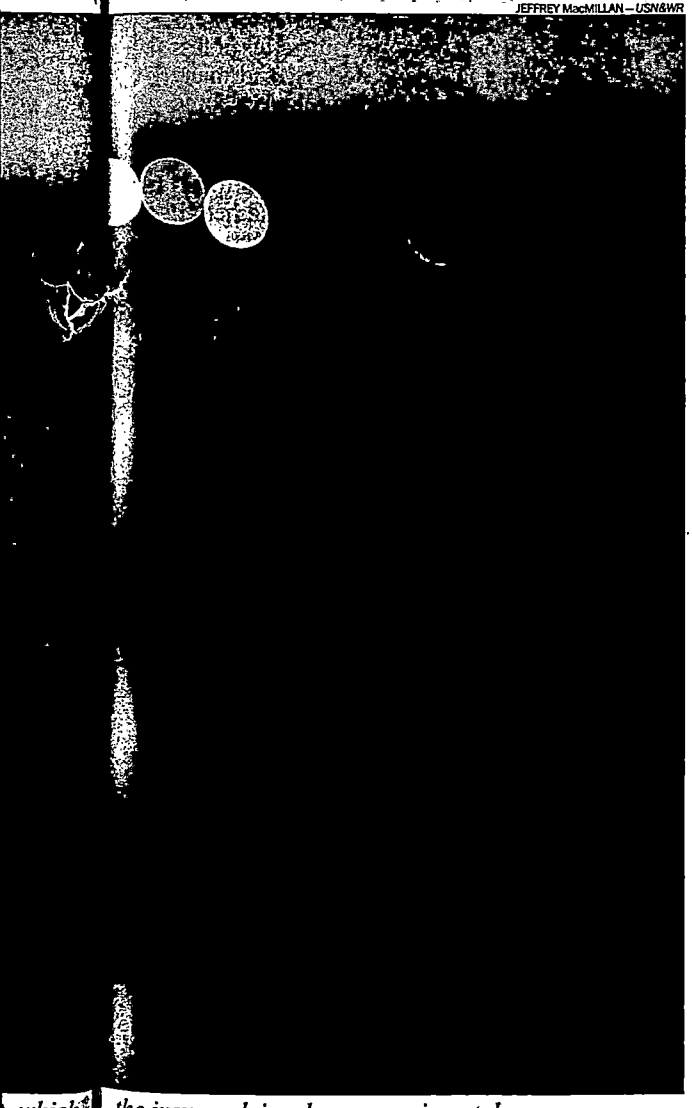
though no hard numbers exist, about half of all appeals to insurance companies to overturn a denial are decided in the patient's favor, says James Cross, medical director of claims payout at The Travelers in Hartford, Conn.

Inconsistencies from one insurer to the next testify to the problem—and spur many consumers to press on. For example, Blue Cross/Blue Shield plans in a majority of states would have covered Hiskey's bill. In fact, the Blues and insurance giants like Aetna, Prudential and The Travelers frequently disagree on whether to pay for newly developed technologies. Aetna, for example, will not pay for—and views as experimental—a new procedure that uses a balloon-tipped catheter to open a blocked urinary tract in men with enlarged prostate glands. But The Travelers covers the $1,500 procedure, citing studies showing it appears to work in some patients.

Cancer treatment has become a particularly bitter battlefield. Cancer center director Mortenson says cancer doctors spend an average of five hours a week arguing with insurance companies over coverage denials. Many of the controversies arise when doctors use chemotherapy drugs approved as a weapon against one form of cancer against other forms of the disease. It is perfectly legal and frequently done, but insurers designate many such "off-label" treatments as experimental.

Cancer cures. Patients such as Brenda Miller, a mother of three who lives in Portsmouth, N.H., suffer the consequences. Miller's doctors told her that her best chance of surviving advanced breast cancer would be to bombard her body with large doses of chemotherapy drugs before receiving a bone marrow transplant. But New Hampshire Blue Cross/Blue Shield refused to pay for the $100,000-plus procedure, calling it experimental. In fact, most Blues plans and major insurers generally cover the combined treatment when it is used against advanced leukemia or lymph-system cancer. Miller sued, and a state Superior Court judge in September ordered Blue Cross/Blue Shield to pay—at least for now—its full share of her medical bills pending the outcome of a lawsuit. Courts in five other states have similarly sided with breast-cancer patients seeking the costly treatment in the last two years.

JEFFREY MacMILLAN—*USN&WR*



, which the insurer claimed was experimental.

Lawsuits should be a last resort, however, when it comes to fighting your insurer. A direct personal appeal is the best initial strategy. Learning exactly why coverage was turned down is the obvious first step, and by law insurers must tell you. Your doctor should then be able to clarify why the denied service was performed. Many denied claims stem from a doctor's or hospital's failure to file the necessary paperwork or to properly justify what actions they took. In such cases, a letter of explanation from your doctor to the insurer may suffice. An increasing number of companies are self-insured, however, meaning that they fund their own health-insurance plan but hire an insurance company to administer it. At such firms, the final word on an insurance appeal legally rests with the employer, not with the insurer; a sympathetic boss may reverse the denial.

The latest wrinkle in the insurance game is utilization re-

What is and isn't acceptable

Most insurers won't pay for treatments they deem experimental or unneeded. Here's a sampling of procedures.

HANK MORGAN-SCIENCE SOURCE/PHOTO RESEARCHERS

Frozen out. *Most insurers reject in vitro fertilization claims.*

ROUTINELY COVERED

- **Laparoscopic surgery.** *A less invasive way to repair hernias or remove the gall bladder or appendix through tiny incisions.*
- **Endometrial ablation.** *Less radical than hysterectomy, done to stop excessive menstrual bleeding.*
- **Clozapine.** *An anti-psychotic used to treat extreme schizophrenia.*
- **Transcervical balloon tuboplasty.** *A tiny balloon is inflated inside the fallopian tube to clear blockages.*
- **Prenatal screening.** *Testing of pregnant women for sexually transmitted diseases.*

OFTEN QUESTIONED

- **Coronary angiography.** *Series of X-rays that detect blockages in arteries that feed the heart.*
- **Positron emission tomography.** *PET scans can spot heart disease and compute blood flow.*
- **Heart-bypass surgery.** *Bypasses blockages of the heart's arteries.*
- **Hysterectomy.** *Removal of uterus; often challenged when less-drastic measures can be taken.*
- **Back surgery.** *Done to treat slipped disks or persistent back pain.*

RARELY COVERED

- **Lithotripsy for gallstones.** *Sound waves are beamed at gallstones to pulverize them.*
- **Adrenal-tissue transplants.** *An experimental treatment for Parkinson's disease that involves transplanting tissue to the brain.*
- **Bone marrow transplants.** *Often denied specifically for ovarian, breast and brain cancers.*
- **In vitro fertilization.** *A test-tube solution when conception is difficult.*
- **Artificial heart.** *Typically denied when used as a permanent replacement for a diseased heart.*

USN&WR—Basic data: Major insurers

view. Firms hired by employers or insurers screen what procedures or treatment doctors recommend for employees based on medical necessity. Denials stemming from a utilization review usually occur during the preauthorization process, when a health plan requires patients to check with the insurer before being hospitalized or undergoing costly procedures. In some instances, though, you may not find out until afterward from your doctor that coverage was denied by a review firm. In either case, you can appeal. There's a stumbling block, however. A doctor may be able to find out generally why coverage was denied but not the specific criteria the review firm used, since those companies tend to consider such information proprietary. The best that patients can do is have their doctors justify to the review firm and the employer why the treatment was necessary.

Flexing your muscles. A doctor's word alone won't carry that much weight, however, when an insurer denies your claim because a treatment is deemed experimental. Clinical studies published in respected medical journals may strengthen your case, as will evidence that other insurers cover the treatment. A denial involving off-label use of a drug warrants checking with independent sources, such as the United States Pharmacopeial Convention's The Complete Drug Reference ($39.95) to learn if the drug is listed as an accepted but still technically unapproved treatment for your condition. Consumer groups such as the National Insurance Consumer Organization, (703) 549-8050, or the Center for Medical Consumers, (212) 674-7105, can help provide other background material.

Doctors may also suggest that you contact your state's insurance commissioner to help fight a denial. Most insurance commissioners' offices are chronically understaffed, however, and simply can't cope with the wash of appeals. California's insurance commissioner gets an average of 4,000 written complaints a month and has a staff of 50 to try to address them. About two thirds don't get answered for 30 days or longer. The National Insurance Consumer Organization wrote Virginia's insurance commissioner on Lorraine Hiskey's behalf in June and has yet to get a reply. Insurance commissioners also lack legal bite. Employers who are self-insured, for instance, operate totally outside state insurance regulations. Still, a letter of complaint to an insurance commissioner's office can't hurt. Some state and local offices are more aggressive than others, and there's always the chance that an official warning or rebuke from the state to your insurance company will tip the balance your way.

Suing insurers for payment may become more common as health costs continue to rise and insurers become even more tightfisted. When tens of thousands of dollars are on the line, a legal battle requiring a lawyer often makes sense. But small-claims courts will hear insurance cases involving disputes of less than a few thousand dollars, and many have been sympathetic lately to people with dire or terminal illnesses who seek experimental or unproven treatments. In today's climate, it's dangerous to assume that even the most routine health service is covered. Making a practice of checking in with the insurance company in advance, no matter what care you are receiving, could avoid a lot of heartache later on. ■

BY STEVEN FINDLAY

JEFFREY MacMILLAN—USN&WR

Aches. *Insurers won't cover Lorraine Hiskey's migraine cure.*

PARTIAL PAYMENTS

Recouping your losses

Critics call it nickel-and-diming; health insurers claim they're merely trying to keep premiums out of the stratosphere and stay solvent. Either way, these days insurers don't want to pay any more of your medical bill than they have to, which may be far less than you think you deserve to get. Here's how to bridge the gap.

■ **Defining "customary."** In traditional fee-for-service health plans, insurers reimburse doctors and hospitals for "customary and reasonable" charges. Aetna, for example, usually won't pay a surgeon more than $1,075 to repair a hernia. But about 15 percent of medical bills exceed Aetna's reasonable level, and its policyholders must pay the difference—as well as coinsurance, the patient's 20 percent share of the covered cost under most plans. Your doctor or hospital should let you know up front what the charges will be, especially for major procedures or tests. A doctor should know if the charges surpass insurer averages. A doctor charging 10 to 30 percent more than usual might waive the balance, though a hospital usually won't. A physician who charges even more than that may inspire you to look elsewhere for medical care.

■ **Is it needed?** Insurers don't want to pay for "unnecessary" care, and the necessity of many procedures does raise real questions. But you may want to challenge any reimbursement that requires you to pay 15 percent or more of the total on top of the coinsurance. The insurer should fully explain the partial payment to you, and your doctor or hospital should be able to justify the charges to the insurer. If that fails, many doctors will waive the contested balance.

■ **Bits and pieces.** To boost revenue, some doctors and most hospitals and clinics break down major procedures into small parts and bill each part separately. That raises your coinsurance, but there isn't much you can do about it. Such "unbundling" also increases the risk that the insurer will reject or only partly pay for individually billed items. Again, a fair doctor or clinic should absorb the extra expenses if you never got a good explanation of the extent and costs of individual tests or procedures.

The Promiscuous World of Pro Sports

10 WAYS TO CURE THE HEALTH CARE MESS

TIME/NOVEMBER 25, 1991

COVER STORY

Condition: Critical

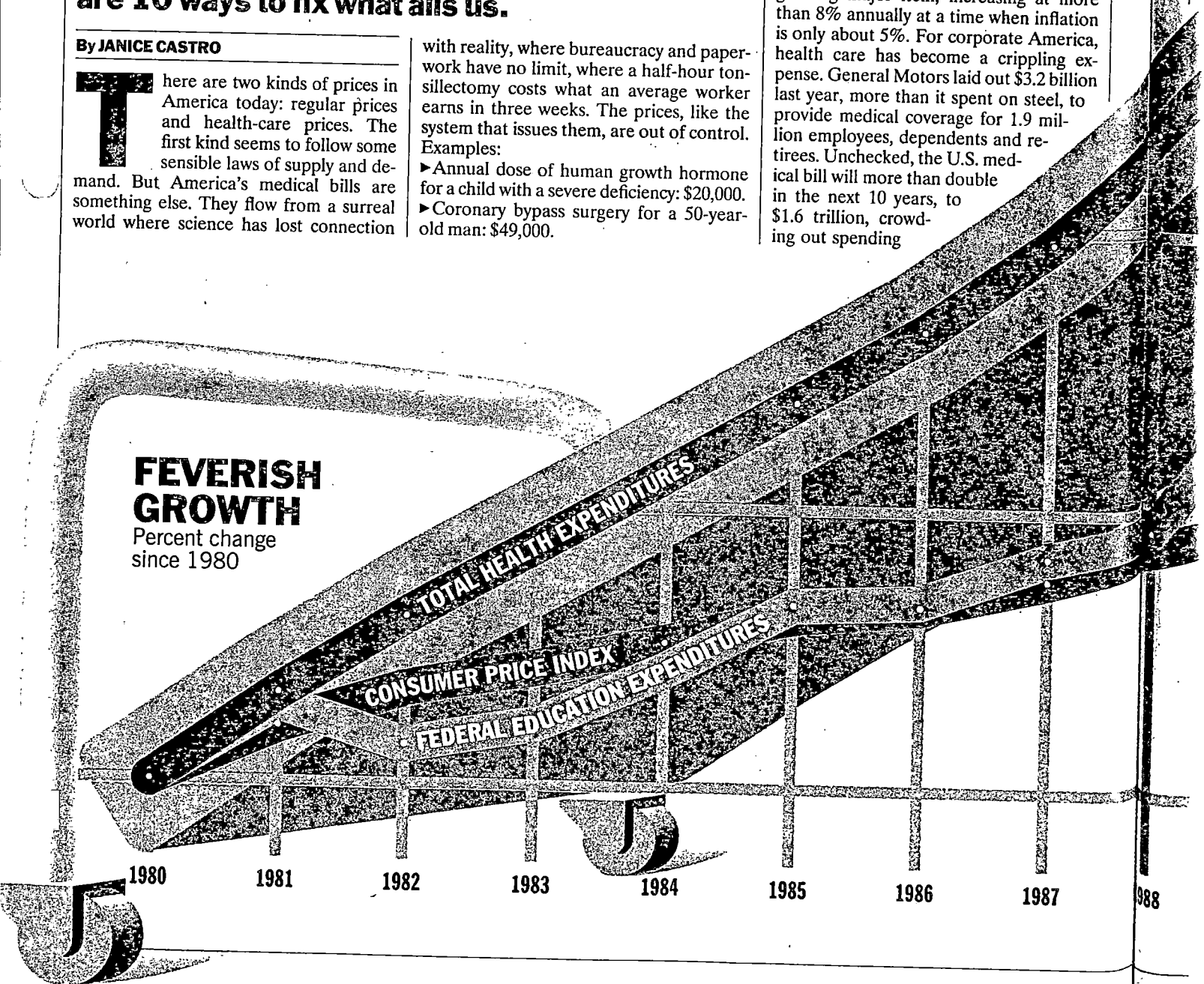
Millions of Americans have no medical coverage, and costs are out of control. Here are 10 ways to fix what ails us.

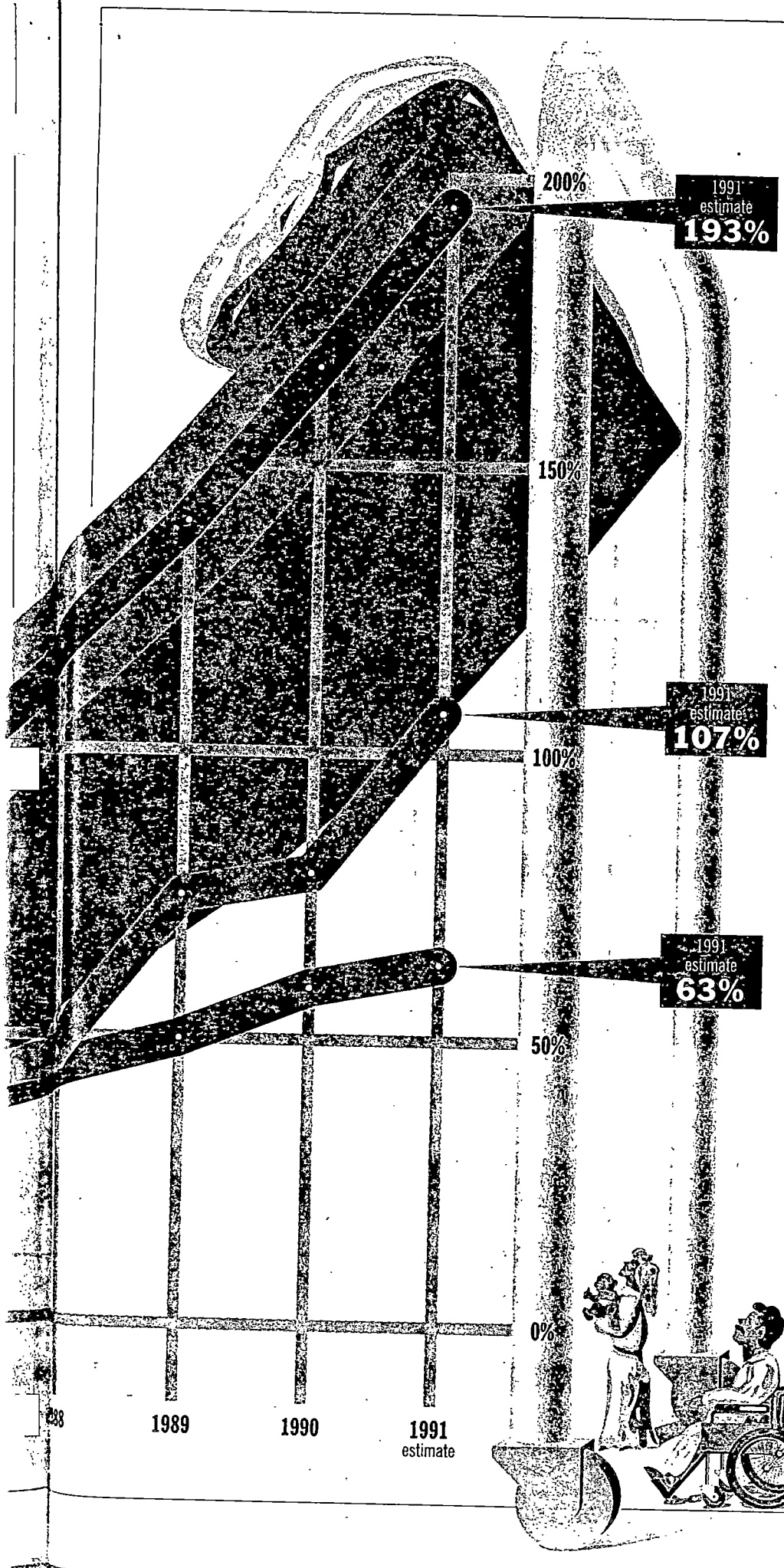
By JANICE CASTRO

There are two kinds of prices in America today: regular prices and health-care prices. The first kind seems to follow some sensible laws of supply and demand. But America's medical bills are something else. They flow from a surreal world where science has lost connection with reality, where bureaucracy and paperwork have no limit, where a half-hour tonsillectomy costs what an average worker earns in three weeks. The prices, like the system that issues them, are out of control. Examples:

- ▶Annual dose of human growth hormone for a child with a severe deficiency: $20,000.
- ▶Coronary bypass surgery for a 50-year-old man: $49,000.
- ▶Cost of a Bufferin tablet for a patient in a psychiatric hospital: $3.75.
- ▶Price of a modified radical mastectomy: $7,900.
- ▶One day's intensive care for a crack baby: $2,000.
- ▶A 50-minute session with an élite psychotherapist: $160.
- ▶Delivery of a baby by Caesarean section: $7,500.

Americans spend $23,000 a second on medical care, more than $2 billion a day, $733 billion a year. That is nearly twice what they spent seven years ago, including annual increases of 10% during the past two years. For the Federal Government, medical costs have become the fastest-growing major item, increasing at more than 8% annually at a time when inflation is only about 5%. For corporate America, health care has become a crippling expense. General Motors laid out $3.2 billion last year, more than it spent on steel, to provide medical coverage for 1.9 million employees, dependents and retirees. Unchecked, the U.S. medical bill will more than double in the next 10 years, to $1.6 trillion, crowding out spending



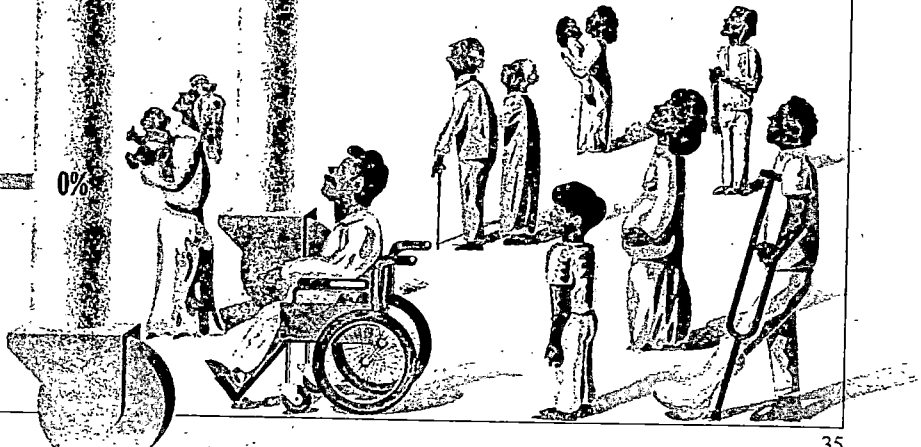


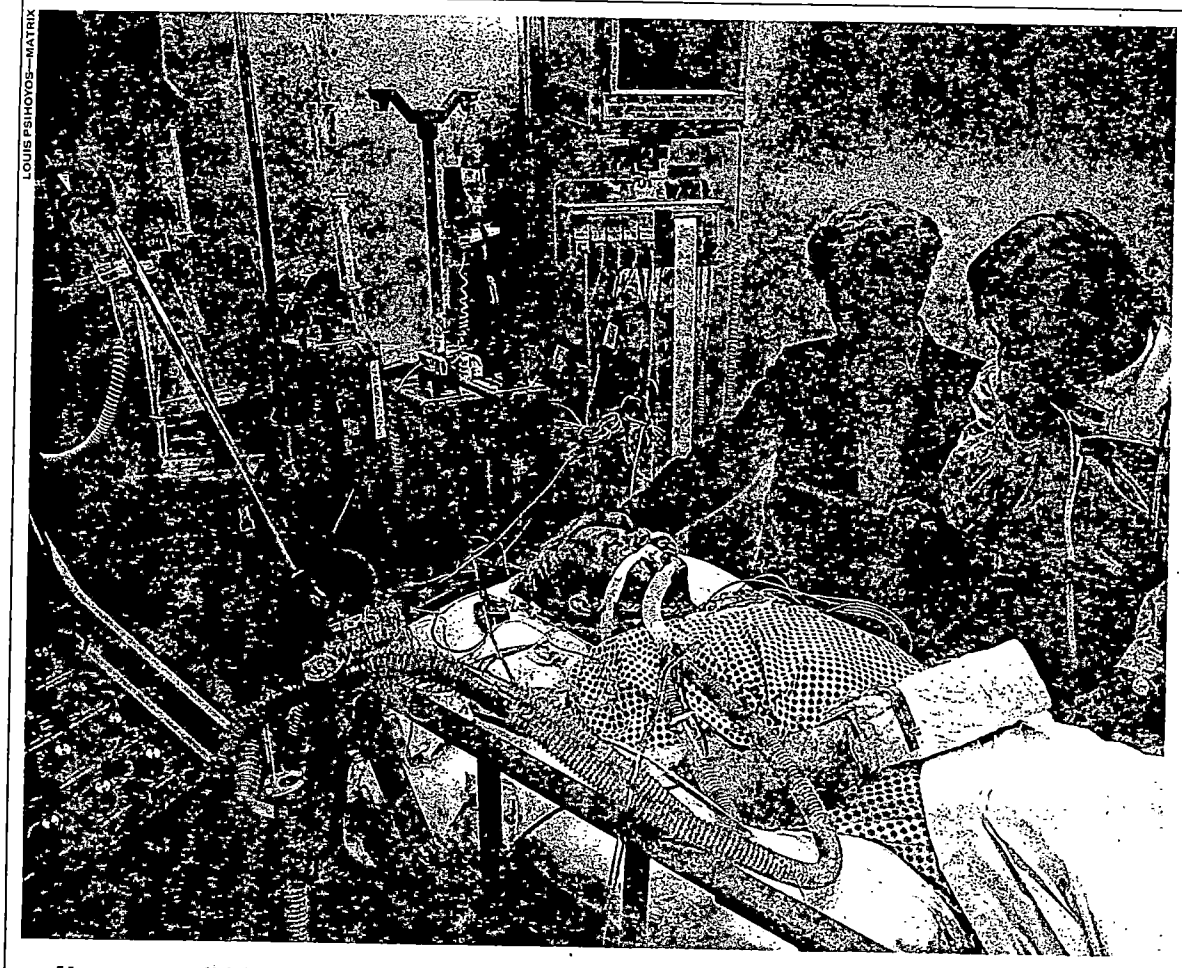
for other urgent needs. "Health-care costs have created an American state of siege," says Florida Governor Lawton Chiles. "It's going to break us."

Suddenly health care is becoming the litmus test of American politics. It was a central issue in this month's senatorial race in Pennsylvania. Little-known Democrat Harris Wofford, who called for a health-care plan that would cover all Americans, easily defeated former Governor Dick Thornburgh. As the 1992 presidential campaign gathers steam, every Democratic candidate is putting universal health care at the top of his agenda. While Nebraska's Bob Kerrey proposes a comprehensive plan that would require substantial new taxes, others, including Bill Clinton and Tom Harkin, are fashioning less costly approaches that emphasize preventive care. Says Harkin: "We don't have to spend a nickel more. We just have to spend it smarter." Congressional Republicans, sensing that the White House is moving too slowly on the issue, offered their own plan earlier this month to provide basic care for uninsured Americans.

How did America's health care slip into such a critical condition? It's all so paradoxical. We're the medical miracle workers. We're the picture of health. We live decades longer than we did before. We've harnessed the body's natural defenses with antibiotics, defeated plagues and diseases, learned how to make spare parts for almost every organ except the brain.

We got what we wished for, a medical miracle system—but all its perilous side effects too. Medicine's amazing new tools have made decent health care a rich man's privilege, too expensive for the working poor and even many middle-class people. Moreover, America may be shackling its economy by investing too much in one industry. The U.S. currently devotes 12.3% of its gross national product to health care, up from 9.4% in 1980. At this rate, within 20 years Americans will be spending a third of all their resources on medicine. Says Daniel Callahan, the director of the Hastings Center in Briarcliff Manor, N.Y.: "We have let ourselves be seduced by the idea that there is no such thing as enough health care."





LOUIS PSIHOYOS—MATRIX

VAST RESOURCES CAN STAVE OFF DEATH: at Columbia-Presbyterian in New York City, a leading research hospital, an elderly patient rests in the recovery room after receiving a heart transplant.

Yet we accomplish less and less. Doctors may waste more than $100 billion a year on overzealous testing and unnecessary surgery, among other things. Insurance companies say patients, hospitals, doctors and thieves are cheating them out of $60 billion or more. Meanwhile millions of Americans are starving for care in the midst of plenty. Doctors have migrated away from rural areas across America, leaving families in dread fear of the tractor accident, the heart attack, the sudden illness. Another problem: the health-care system devotes so much of its resources to last-minute miracles that it neglects the more mundane realm of preventive medicine, where many terrible illnesses could be halted sooner or avoided altogether. "We have to rearrange how the dollars are being spent and refocus them on earlier stages of illness," says Jeff Goldsmith, a health-care adviser to the accounting firm Ernst & Young.

Americans used to take health care for granted. But now they can see the cracks in the system—and those gaps scare them. The prospect of an additional 30% increase in medical costs next year has prompted many employers to cut their work force, reduce health benefits, or both. At the same time, insurance companies are raising premiums to nigh unaffordable levels. Millions of workers are terrified of losing their coverage.

Until now, attempts at reform have run into a gridlock of powerful constituencies: giant corporations, doctors, hospitals, insurance companies and the highly organized senior-citizens lobby. But popular opinion may break the impasse. In a TIME/CNN poll of 1,000 adults surveyed by Yankelovich Clancy Shulman, 91% said that "our health-care system needs fundamental change." Most of those polled, 75%, said costs are much higher than they should be, and 83% said they would cut costs by limiting doctors' fees. Two-thirds said health care is a right, and 70% said they would be willing to pay higher taxes to ensure that all Americans have coverage. Last week the National Leadership Coalition for Health Care Reform, a group of big companies and labor unions, put forth a proposal to require all employers either to provide health insurance or to pay a new 7% federal payroll tax to fund public coverage.

The U.S. can do a much better job with the money it is spending by balancing compassion with realistic notions of what can be done. It is not possible to offer unlimited medical care to everyone, nor fair to cushion the well-to-do with vast public-health-care subsidies while millions of American children and their parents go without. It's time for a cure.

On the following pages, TIME looks at 10 of the most important problems in the American way of medical care. Here are some suggestions on how to fix them.

1. THE BASICS

About 1 out of 9 American working families, a total of 37 million people, has no health insurance at all. Most of the uninsured are the families of workers in small firms that do not offer such coverage. Among the uninsured are an estimated 8 million American children growing up without adequate medical and dental care. About 17% of all Americans suffering from diabetes and high blood pressure are going without treatment, according to Robert Blendon of the Harvard School of Public Health.

Medicaid is supposed to insure those who cannot pay for coverage, with each state making that determination according to its own means test. But even this voracious state-and-federal system—which cost $2.3 billion in 1967, the first full year after it was launched, and now costs 69 times as much—can barely afford to help 40% of the poor. In 1980 the figure was 65%. As hard-pressed states have found it increasingly difficult to pay for the program (they put up 68% of the total money), they have tightened eligibility standards. As a result, more and more working Americans earn too much money to qualify but too little to afford care. In Alabama a family of four cannot qualify for Medicaid if it earns more than $16,584 a year.

SOLUTION: Establish a universal health-care plan covering basic preventive treatment for all Americans who cannot pay for their own insurance. Nearly two-thirds of the 500 senior executives surveyed last summer by the consulting firm Noble Lowndes said they support such a plan. To help pay for it, Congress should eliminate the $53,400 income cap on the payroll tax that funds Social Security. While this would sharply increase payroll taxes for the wealthiest, such a change represents a more equitable way of apportioning the burden, which now falls more heavily on lower-income workers. Removing the cap would provide an estimated $25 billion in new funds for the universal plan. Congress should then shift the entire federal Medicaid budget to the universal-health program, which would give it a generous $115 billion in its first year.

To control costs, care must be delivered through tightly managed private systems, such as a network of health-maintenance organizations (HMOs) or cost-conscious doctors and hospitals that provide moderately-priced services. Patients must have a financial stake in making sensible use of the system. They would benefit based on their ability to pay; deductibles and co-payments would sharply rise as one's income increased. High-cost medical procedures would be closely screened for their anticipated value in extending life and health.

2. MEDICAID

The fastest-growing spending program in the U.S., Medicaid will dispense $158 billion in federal and state funds this year to provide health care to 27.3 million Americans. Costs are careering out of control. Medicaid pays for half of all nursing-home patients—or 250,000 Americans—at an average annual cost of $34,000 a person. Medicaid also looks after the 158,000 severely impaired crack babies born every year ($1.8 billion a year), the 35,000 AIDS victims who have run out of money, the poor single mothers and pregnant teens, the hardest-pressed Americans.

It doesn't do a very good job because the rules governing the delivery of care are unrealistic and wasteful, often requiring hospitalization, for example, where outpatient treatment would suffice. Moreover, many doctors refuse to treat Medicaid patients because of rock-bottom reimbursement and the snarl of bureaucratic rules. The program is also a sitting duck for thieves because of poor administration. Medicaid pays billions in fraudulent insurance claims for nonexistent patients.

SOLUTION: Shut it down. Medicaid patients can receive better care, and the federal contribution would be better spent, under the simplified universal plan proposed above.

Oregon's Value Judgment

Virtually every state in the U.S. is struggling to find ways to seal up increasingly leaky health-care systems. Hawaii was one of the first to strive for universal coverage and now reaches 98% of its residents. Florida, New York, Michigan, Maine and Wisconsin subsidize health-insurance coverage for some of their poorest citizens. South Carolina sponsors house calls for pregnant women. Alabama uses its school clinics to provide prenatal care. Despite this kaleidoscope of experiments, no one state can claim to have solved all its problems.

DAVID FALCONER FOR TIME

Doctor and patient, 2, at a county health center

The newest and broadest attempt to improve access and contain costs is taking place in Oregon. The state is asking the U.S. government to approve changes in Medicaid rules to provide a limited list of medical services to all people below the poverty level, regardless of their current Medicaid status. A companion law in Oregon's comprehensive health plan requires all employers to provide health insurance for full-time employees and obliges insurance companies to renew those policies without excluding individuals considered too risky. The state also guarantees that doctors and hospitals are reimbursed for their services but makes them justify their purchases of costly medical diagnostic equipment.

The centerpiece and most controversial feature of the plan is a list of 709 medical conditions and their treatments, ranked according to their seriousness and the likelihood that treatment will restore the patient to long-term good health. Actuaries estimate that state and federal Medicaid money will pay for treatment of everyone suffering from the first 587 conditions on the list.

In effect, Oregon is promising to provide universal coverage in exchange for a system of financial triage. A child will get a liver transplant; a chronic alcoholic will not. An AIDS sufferer will get treatment in the early stages of his illness but in the terminal stages will get only "comfort care." The plan would not pay for so-called heroic measures, such as expensive life support for babies born after less than 23 weeks of gestation and weighing less than 500 g (1.1 lbs.). Nor will it pay for self-curing ailments—now covered—like the common cold, food poisoning, sprains and simple diaper rash. And, of course, the patient who needs spinal disc surgery, No. 588 on the list, may be out of luck.

Oregon's list is not without critics. The Washington-based Children's Defense Fund is actively lobbying against the Medicaid waiver needed to put the plan into effect. Says CDF director Sara Rosenbaum: "We don't understand why the state's poorest children have to give up literally life-and-death benefits for the sake of this social experiment."

But many Oregonians are in favor of it. The pecking order of conditions was arrived at with the help of marathon discussion sessions that were organized by Oregon Health Decisions, a public interest group, and held in each of the state's 36 counties. But agreement on values does not guarantee fiscal manageability. "We're all together on this, but for many different reasons," says Amy Klare of the Oregon AFL-CIO. "Business will fall off if the plan's too rich. We'll fall out if the plan's too weak." Ellen Pinney, executive director of the Oregon Health Action Campaign, wonders whether coverage will be maintained at the initial levels. "Over time," she contends, "the ability of the state to fund an adequate plan will be constrained."

State officials admit that some changes are certain to take place in 1993, when treatments for mental health and chemical dependency are added, as well as coverage for senior citizens and the disabled. Then somebody with condition No. 587 may no longer qualify. But if the plan works, virtually every Oregonian will be assured decent primary care, and that is a goal with which every community could live.

—By Edwin M. Reingold/Salem

ANDY LEVIN—PHOTO RESEARCHERS

HOUSE CALLS MAKE ALL THE DIFFERENCE: in Mississippi a visiting nurse checks up on her homebound elderly patient. Without such help, he might face the trauma of moving to a nursing home for care, at considerably greater cost.

3. MEDICARE

This $110 billion program—which started out 26 years ago with a budget of $5 billion—was designed to provide decent care for the elderly. But the program gives the same benefits to those who are well-off as to the elderly poor. Though the elderly do pay some of the costs—and staunchly resist bearing more of them—nearly 90% of Medicare funds come from payroll taxes on workers. As a result, the burden falls partly on laborers who have no health insurance of their own and may have trouble making ends meet.

The burden on younger Americans is growing more onerous as the U.S. population ages, bringing with it the responsibility of caring for millions of elderly with enormously expensive medical needs. There are now about seven Americans under the age of 65 for every person over that threshold, compared with 11 to 1 in 1960. One of those younger Americans is unemployed, and two are children. That leaves about four workers to support each elderly American. And one of those doesn't even have his own health insurance.

SOLUTION: To slow its runaway growth, return the program to its original goal: taking care of people who need financial help. People who can afford to pay more for their own health care should do so. In addition, subsidies should be more carefully rationed when it comes to extremely complex and costly medical procedures for very old patients. "Most of the elderly would probably accept that idea," says Dr. Perry Stafford, a surgeon at Bethesda Naval Hospital in Maryland. "It is usually their families who have this tenacious hold on anything that will prolong life. It is hard for people to see that at some point, you are prolonging death, not life."

4. FRAUD AND ABUSE

How does an insurance company know whether a patient really got the care for which it picks up most of the tab? Doctors and hospitals are on the honor system, but some of them cheat. Fraud may account for as much as $75 billion of annual U.S. health-care expenditures, according to the National Health Care Anti-Fraud Association. Last June California officials uncovered the biggest single medical fraud to date, a $1 billion rip-off carried out by thieves operating clinics on wheels. Investigators say the clinics offered patients free tests and exams, then used their insurance information to generate a huge number of fake bills. In a similar scam in New York City, a doctor billed Medicaid for $50,000 worth of lab tests for a single patient.

Innumerable smaller crimes are committed daily in labs, hospitals and doctors' offices to inflate the costs of care, often under the guise of doing patients a favor by circumventing cumbersome insurance regulations. Some doctors and dentists give patients inflated bills in exchange for slightly higher than normal fees. The patient collects his own kickback in the form of a bigger insurance refund. Some hospitals and doctors bill for treatment they did not provide. In a survey of Aetna Life & Casualty customers, 4 out of 10 consumers said their doctors had cheated insurance companies.

Physicians also have conflicts of interest that contribute to vast waste, reformers say. In a study released in August, Florida officials reported that doctors owned 93% of the diagnostic-imaging centers surveyed, 78% of the radiation-therapy centers, 60% of the clinical labs and 38% of the physical-therapy and rehabilitation centers. Miami doctors prescribe MRI scans (cost: $800) and various lab tests about twice as often as doctors in Baltimore, where very few own the equipment. Lab charges are more than twice as high at facilities owned by doctors.

SOLUTION: Tougher enforcement. Insurance companies and public authorities should pool information on fraud via computer networks. At the very least, this would prevent thieves from simply repeat-

A DESPERATE RACE FOR HELP WHEN NO DOCTOR IS NEAR: hit by a car in a remote area of central Texas, an eight-year-old boy is rushed to a helicopter for a trip to the nearest emergency room. Instead of a risky 45-minute journey by road, the chopper can get him there in eight minutes.

g their crimes later in fresh territory, as ny now do, thanks to lax record keeping program administrators. In addition, ysicians and hospital officials must po- e their own ranks and blow the whistle dishonest billing practices. Stricter po- ing will cost more, but it should pay for elf many times over.

At the same time, doctors should be re- ired to disclose to patients their invest- ents in testing centers and laboratories. d offer an alternative in which the doctor es not have a financial interest. (That oposal has already been recommended the American Medical Association's ouncil on Ethical and Judicial Affairs.)

5. DISAPPEARING DOCTORS

More than 570,000 physicians practice edicine in the U.S. today, almost double e number 20 years ago. Yet huge eas—18 counties in Texas alone—have ne. Rural America, like many inner cit- , is facing a crisis in primary care. Com- unities need about 35,000 more general actitioners, according to most esti- tes. Doctors typically prefer more lu- tive practices as specialists and sur- ons (who can earn more than $300,000 ear, compared with the average family ctitioner's income of $96,000). The rtage of general practitioners leads to wasteful use of medical resources. Without a family doctor to keep track of their overall health, people are left to find their way through a costly medical system ache by ache, often seeking high-priced help where the skills of a generalist would more than suffice.

SOLUTION: Federal money pays for half of graduate medical education. Redirect as much as 50% of that $3.6 billion federal contribution to students who aim to practice primary medicine.

Expand a three-year pilot project authorized by Congress last year. The program provides up to $50,000 in matching funds for communities that finance medical education for physicians (cost of training: about $75,000) as well as other medical professionals. This plan was prompted by the experience of Dr. Roger Pelli. A resident of Ashland, Me. (pop. 1,800), a town without a doctor, Pelli promised in 1982 to care for the people in the Ashland area if they would help send him to medical school. Six local towns raised $15,000 a year for his education. Today Pelli takes care of 3,000 people scattered over the surrounding area, making house calls, handling everything from chain-saw injuries and cardiac arrest to births and vaccinations. Says Ashland town manager Nancy Farris: "He's always there, and he always greets his patients with a smile, no matter how tired he is. The only thing is, he's working too darned hard."

Pelli's emotional commitment is all the greater because his patients are his friends. Not long ago, a young woman in town was fatally injured in an auto accident. Recalls Pelli: "I couldn't revive her. All the time I was trying, I could hear her two young children, her husband and her parents crying. It was just heartbreaking." Says selectman Ray Beaulier, who doubles as the town mail carrier: "Roger is as close as you can get to the old country doctor."

As an additional incentive for doctors who have already finished school, waive taxes on the first $40,000 in income for those who treat patients in designated neglected areas. Expense to the U.S. Treasury: approximately $9,000 a year for an unmarried doctor with no dependents. As well as being worthwhile in itself, this investment in basic medicine would also produce other kinds of savings by preventing unchecked chronic disease and producing healthier and more productive citizens.

6. PHYSICIAN COMPENSATION

Back when doctors were paid out of patients' pockets, there were natural brakes on the amount of medical service prescribed and the charges levied. For one

WEINBERG—CLARK/IMAGE BANK

MODERN MIRACLES, FOR THOSE WHO CAN AFFORD THEM: a radiology technician gives a CAT-scan test to a patient. Such new technologies save lives but also dramatically increase the cost of care. Lacking insurance, many Americans must make do with less help.

thing, doctors knew their decisions could devastate a family's finances. And patients who paid their own bills yelped at high prices. But concerns over costs diminished over the past 40 years as vast insurance pools were created through company benefits plans and the huge Medicaid and Medicare systems.

Under the circumstances, insurance is like a blank check. Research has shown that doctors paid in fee-for-service programs order 50% more electrocardiograms (about $27.50 each) and 40% more X rays ($62 for a frontal-lateral chest X ray) than physicians in managed-care groups. Says Edmund Kelly, group president of Aetna: "The problem with our medical financing system is that most doctors get paid for doing things to people, not for keeping them healthy."

Medicare and insurance companies have tried to make sense of medical charges by establishing maximum fees for hundreds of surgeries, tests and procedures. But the medical establishment is winning the accounting war. Some doctors attend seminars on "creative billing," learning how to describe medical treatment in terms that will yield the highest prices. A $2,900 gastrectomy, the removal of all or part of the stomach, can be billed à la carte as several procedures for a total of $6,900. When auto-repair shops or lawyers do that, we call it padding the bill. Doctors call it "unbundling." Some maintain that they do it in the spirit of Robin Hood, overcharging people with good insurance in order to charge less for the treatment of poorly covered patients.

SOLUTION: Managed care. Providers of group insurance should insist that doctors treating their patients be paid salaries or flat fees. Such a system is already employed by many HMOs, which charge group-insurance plans an annual fee for treatment and produce often dramatic savings. Treating 40 million Americans last year, HMOs cost an average of $2,68 per person, 17% less than the $3,214 cost of traditional indemnity plans, according to a survey conducted by the Foster Higgins consulting firm. Doctors bound by such strictures would still be free to earn extra income by treating other, higher-income patients in private practice.

7. UNNECESSARY CARE

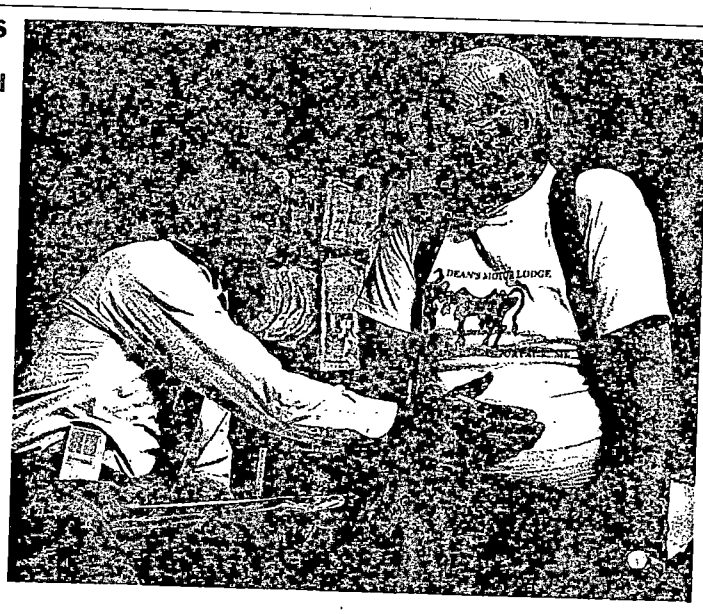
Fear of malpractice lawsuits drives doctors to perform many extra procedures to protect themselves against accusations of negligence. The A.M.A. estimates that defensive medicine adds $21 billion to the U.S. health-care bill every year. Other experts, including former U.S. Surgeon General C. Everett Koop, believe the cost is several times that high. Some reformers think juries in malpractice cases share the blame by punishing doctors not only for shoddy practice but also for their human limitations. "Medical care is not always successful," says Aetna's Kelly. "But that doesn't mean the doctor should have to pay huge awards for pain and suffering."

Then again, many doctors and hospitals overtreat patients simply because they have a blank check to do so under many insurance programs. As much as 20% of all medical procedures and treatment is completely unnecessary, contends Dr. Robert Brook, director of health sciences for the Rand Corp. Cost of the waste: $132 billion a year. Aetna estimates that as much as 30% more ($198 billion) is discretionary care that may not solve the problem under treatment.

Rand studies have found that in some regions of the country as many as 44% of coronary bypass surgeries and 64% of artery-clearing carotid endarterectomies were either unnecessary or highly questionable. In a separate review for the Philadelphia Professional Standards Review Organization, Dr. Allan Greenspan found that about 25% of heart-pacemaker implants performed in the Philadelphia region were inappropriate. Many doctors challenge such findings, arguing that it is better to err on the safe side.

In the same vein, some extremely expensive technologies are used even before

A SMALL TOWN'S BEST FRIEND: Ashland, Me., had no doctors until Roger Pelli decided to fill the need. Says he: "I get a great deal of satisfaction from really helping people. I am somebody here, not just another car on the road."



STEVE LISS FOR TIME

it is clear that they're needed. That may be the case with at least one new biotech drug, Centoxin, which is available on a limited basis to treat hospital-acquired infections that can cause fatal septic shock (estimated cost: $3,800 a dose). Trouble is, since the condition can kill so quickly, doctors will have to decide whether to administer the drug before they are sure the patient needs it.

SOLUTION: For malpractice cases, cap noneconomic awards for factors like pain and suffering at about $250,000. California placed a limit on such awards in 1975, and it now has some of the lowest malpractice premiums in the U.S. One reason: ambulance-chasing lawyers have less incentive to bring questionable claims.

Another wise investment: devote more research to finding out which procedures and drugs are most effective. If doctors can be supplied with better, consensual guidelines about what works in treating various ailments, they will feel less pressure to do things on a just-in-case basis. They also will be better protected against unwarranted litigation. It is important, though, that such standards be viewed as guidelines, rather than rules that might impinge upon a doctor's best sense of what a patient needs. "Judgment is an important factor in medicine," says Dr. Robert Heyssel, president of the Johns Hopkins Hospital. "Doctors disagree all the time about whether a carotid endarterectomy or a coronary bypass will offer a patient the best shot at recovery. There are no absolutes around these things."

Finally, set maximum reimbursement levels for high-cost pharmaceuticals. Drug firms are among the most profitable in the U.S. And $3,800 a dose is too much.

8. THE HOSPITAL GLUT

America has too many hospitals. On average, U.S. hospitals are operating at 64.5% capacity. To fill their beds, some hospitals buy physicians' practices and then pay the doctors under so-called census-based compensation, which is geared to the number of patients the physicians send to the mother ship and the number of procedures they perform. Some hospitals pay doctors in other ways—through honorariums or appointments to hospital boards—as a reward for referring patients.

SOLUTION: Remove the more blatant conflicts of interest governing the relationships between doctors and hospitals. Outlaw census-based compensation for doctors. Require physicians to disclose their financial relationships with the hospitals to their patients.

Companies as well as federal and state programs should encourage doctors to refer those patients who do not need the full range of hospital services to less costly outpatient clinics. Simple fractures, for example, often can be treated in this way. Pay doctors and hospitals less for clearly wasteful practices.

Eliminate tax subsidies for underused and obsolete hospitals. Together with the discipline of managed care and physician disclosure requirements, this change will help weed out vestigial institutions so that taxpayer support for health care can be put to better uses.

9. FAIRNESS

Taxpayers, even those who have no insurance, spend an estimated $84 billion a year to subsidize medical care for mostly middle- and upper-class Americans. That is because companies can write off every dollar they spend on health care as a business expense, which may help explain why corporate America did so little to contain the costs until they got out of hand. At the same time, employees who enjoy generous benefits plans pay no taxes on the thousands of dollars in health-care coverage that their companies provide for them.

SOLUTION: Reduce the corporate write-off for medical costs. And impose a tax on employee health benefits at a moderate rate for well-compensated workers.

10. WASTE

The U.S. has more than 1,500 different health-insurance programs, each with its own marketing department, complex forms and regulations. Doctors, nurses and clerks are buried in the paperwork needed to keep track of whom to bill for every aspirin tablet. It's a massive waste of time. U.S. health-care providers will spend as much as $90 billion this year on record keeping, according to a Harvard study.

SOLUTION: Standardize insurance forms. Maryland did so 20 years ago. Partly as a result, the cost of a hospital stay at top-rated Johns Hopkins in Baltimore, which was 25% above the national average before the system was put in place, is now 7% below the average. Louis Sullivan, the Secretary of Health and Human Services, proposed a national plan earlier this month to standardize health-insurance forms. If his program is carried out by the end of the decade, Americans could save as much as $20 billion a year. Just as important, eliminating wasteful paperwork would leave doctors and nurses more time and resources to care for patients.

Cleaning up the health-care system will be an epic adventure in compromise. No one wants to give up his share of medicine's glittering promise, whether it comes in the form of pills or paychecks. But the problems won't wait: health care has emerged as the most important domestic issue of the '90s. "At some point," says Missouri Congressman Richard Gephardt, "no one will be able to afford health care. We have got to act."

While no treatment manual for American medicine should focus purely on its price, controlling costs is critical. If the medical experts are right, the U.S. could save at least $200 billion a year simply by curbing fraud and unnecessary practices. We know where the problems lie. Doing something about them is at the very least our moral duty and is profoundly in our self-interest as a nation. Depriving millions of Americans of health care is wrong. Wasting billions of precious medical dollars on paperwork, dead-end procedures and outright theft is stupid. Undermining the health of our workers and children for lack of political gumption is suicidal. It is time to make the hard choices.

—With reporting by Mary Cronin/New York, Barbara Dolan/Chicago and Hays Gorey/Washington, with other bureaus

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Next month we will examine some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorced, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

Photos: CYNTHIA JOHNSON

Crisis: Delayed care

John Andrusyshyn worked in a Nevada casino. Three summers ago, he noticed a mole growing on his chest, but said nothing about it to his family. He could not afford to pay another bill, so he put off seeing a doctor. Andrusyshyn was not eligible for insurance from his employer until he had been at his job for a year; he couldn't afford his own coverage on the $880-a-month he was bringing home to support his wife, Karen, and two children, Laura and Nikolai (pictured at right).

Several months went by before Karen insisted he go to a doctor. Because dermatologists in Reno were booked up, three more months passed before a doctor examined him. By then, the mole had ulcerated, and John was so desperate for treatment he paid for the visit with a bad check.

The diagnosis was a malignant melanoma that was already coursing through his body. By the time he underwent surgery, he was eligible for insurance from the casino. But Karen had to scrape together $56 a week to pay his share of the premiums, forgoing food and other necessities. The policy covered the hospital bill, but not the $4000 surgeon's fee. On John's medical records, doctors noted: "Patient has no money; we'll do the best we can."

Soon afterward, the Andrusyshyns traded in their mobile home for a '62 Airstream trailer plus $1500 in cash, borrowed a credit card from a relative, and headed for Canada where John was born. As a Canadian citizen, he was entitled to free medical care. In Montreal, doctors tried various cancer treatments, including brain surgery, which he could not have paid for in Nevada. But treatment came too late. Last fall, at the age of 54, John Andrusyshyn died.

"Had we had the medical care available in Nevada like we have here, he would have said something to me," Karen says. "A little thing like an early diagnosis could have added four or five years to his life. That would have meant a lot to this family."

Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 23 other nations in the percentage of babies born with an inadequate birth weight and ranks 22nd in the rate of infant mortality, behind such countries as East Germany, Spain, and Singapore.

Shifting the cost

When the uninsured are able to obtain health care, everyone pays. Each year thousands of people are dumped into emergency rooms of public hospitals because private hospitals don't want patients who can't pay.

In 1988, unpaid hospital bills totaled more than $8-billion, up 10 percent from the previous year. To recoup the costs of unpaid care, hospitals and doctors simply raise their fees to those who do pay—primarily the private insurance carriers and the Federal government.

Such cost-shifting drives up the price of insurance, resulting in even more people who can't afford coverage. In New Jersey, for example, every hospital bill now carries a 13 percent surcharge, reflecting the hospital revenue lost to unpaid bills. That, in turn, feeds into higher insurance premiums.

Cost-shifting accounts for about one-third of the increase in insurance premiums, which are rising as much as 50 percent a year. The cost of medical care—which is increasing two to three times faster than the rate of inflation—is responsible for the rest.

Unaffordable premiums

The higher the price tag for insurance, the more people who go without it. Firms with fewer than 100 workers employ about one-third of the work force in the U.S., but only about half of them offer health insurance to their employees. Small-business owners say they have enough trouble staying afloat without assuming the heavy burden of health-insurance premiums.

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 48 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987, 25 percent of the uninsured worked for very large employers, most of whom offered health insurance.

People who want coverage and must buy it on their own have little choice but to pay what the insur-

ance company demands. In many instances, that can mean thousands of dollars each year. And premiums continue to rise dramatically.

Consider Stephen Beidner, a part-time worker at a California winery. When he first took out a policy with a company called Consumers United Insurance in 1985, he paid $912 a year. By 1989, his premium had jumped to nearly $3600.

Last year, after Beidner had arthroscopic surgery for a knee injury, the company hiked his premium a whopping 93 percent to $6900. After Beidner protested, the company reconsidered his case and let him raise his deductible from $100 to $1000. His new premium: $2177 a year.

Less coverage for many

Beidner is hardly alone in having to settle for less coverage. Spiraling premiums also affect millions of people whose employers provide their health insurance.

One major employee-benefits survey found that employers now spend an average of $2700 annually to cover each employee. In many cases, employers are shifting some of those ever-increasing costs to their workers by requiring them to pay a greater share of the premium and a larger portion of their medical expenses through higher deductibles and copayments. Other companies, such as American Airlines, try to reduce their insurance bill by refusing to cover preexisting health conditions for new employees.

In 1984, Hewitt Associates, a benefits consulting firm, found that 37 percent of large employers paid the full premium for their workers. By 1988, that figure was down to 24 percent. In 1984, 53 percent of large firms paid all hospital room-and-board charges for their workers; in 1988, the figure was 29 percent.

Losing coverage

About half of all large- and medium-sized firms try to trim their

Crisis: Benefits end, costs don't

David Curnow, 47, was a partner in a San Diego law firm. One Saturday, while riding his bicycle, he was struck by an uninsured motorist. After two months in intensive care, Curnow emerged a quadriplegic, paralyzed from the chest down.

His law firm had self-insured its employees' health coverage, agreeing to cover the first $7500 of a worker's claim, and paying premiums to an "excess-risk carrier" to cover the rest.

After the first $7500 was paid, the carrier refused to pay its share of Curnow's bills. Months passed. Doctors, hospitals, and companies providing necessary medical supplies dunned Curnow for payment.

Eventually the carrier paid most of Curnow's bills, which totaled nearly $250,000. But he is still waiting to be reimbursed for the services of the home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some $1500 each month—comes out of his pocket.

Curnow has another problem—how to pay for his continuing medical bills when insurance benefits from the law firm run out. If he doesn't work again, his disability will eventually qualify him for Medicare. But he will still have no insurance for services Medicare doesn't cover. Nor will he be able to buy any. Companies usually don't sell Medicare-supplement policies to the disabled under age 65. If he goes back to work, he must find a job in a large law firm whose insurance company doesn't require employees to be in perfect health. If he opts for a conversion policy from the company now insuring employees in his old firm, he will have to pay $6000 a year.

"How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance?" he asks.

insurance outlays by self-insuring. They invest the money they would otherwise spend on premiums and pay employees' claims directly when they arise.

The Employee Retirement Income Security Act (ERISA) exempts these self-insured plans from state insurance regulations meant to protect consumers. For example, employers may not have to offer certain coverages, such as care for newborn children, or provide for continuation of coverage when employees leave.

Employers hire a third-party administrator, or TPA, to handle the claims. Because the administrator may be the local Blue Cross plan, employees may think that Blue Cross (or some other insurer) is actually underwriting their coverage. Little do they know that the loopholes created by ERISA can leave them without insurance if things go wrong.

If the employer goes out of business or drops the coverage, employees could be out of luck.

The woes of HMOs

When a health maintenance organization closes its doors, the people who received medical care there may also be left uninsured.

Established as alternatives to traditional insurance policies, HMOs provide a variety of prepaid health services to their members . Unfortunately, a number of HMOs have fallen on hard times.

Several states don't require conversion policies or continuation of coverage for members whose HMO has gone out of business. Even in states that do, HMO members have no assurance that their new coverage will be anything like the old. They may well find themselves assuming a greater portion of their medical expenses.

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

After the bankruptcy filing, Blue Cross and Blue Shield of Ohio took over Maxicare's subscribers. Stroup assumed that his $12,000 annual drug bill would be covered for the rest of his life. But Blue Cross had other ideas. It offered Stroup, who had turned 65, a Medicare-supplement policy that covered his drugs only after he paid a $2500 deductible and $1000 in coinsurance.

Stroup and his wife must now pay some $7000 a year for insurance premiums and drugs out of their $10,000 income from Social Security disability. They expect their $60,000 life savings to be depleted in 3½ years.

Clinging to coverage

Millions of Americans have yet to lose their insurance but could at any time fall victim to an insurance company's business practices. As healthcare providers continually raise their fees and pass on the higher cost of medical care to insurance companies, the companies respond by insuring fewer people. People who must buy coverage on their own and workers in small firms feel this pinch the hardest.

Insurance companies are not charities. Their goal is to make a

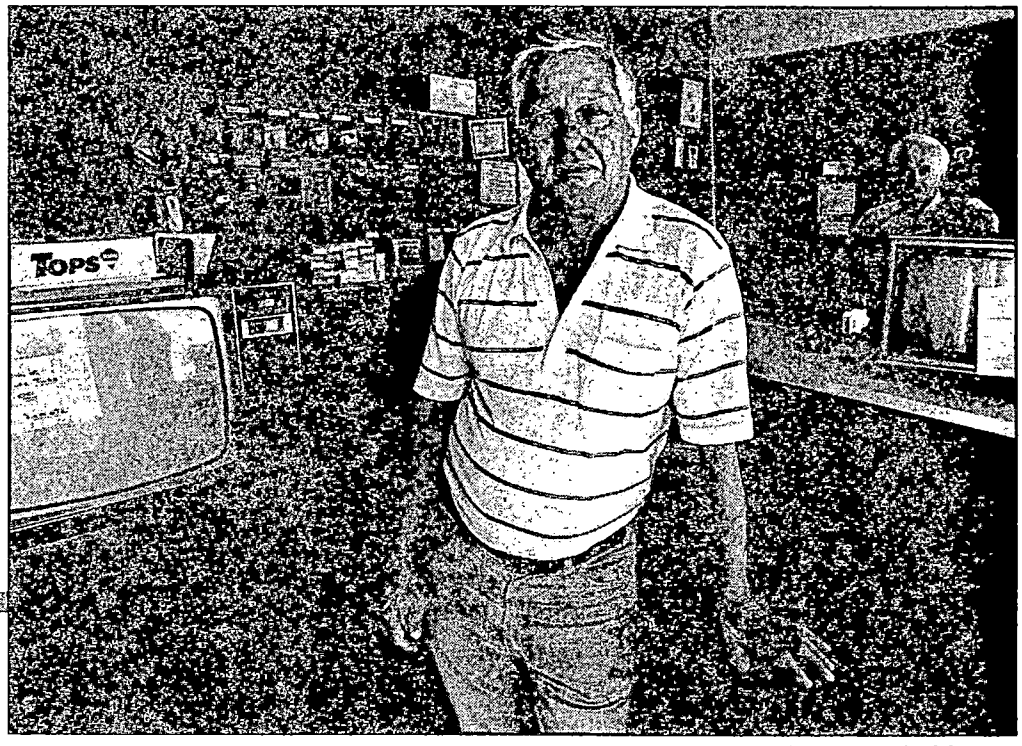
Crisis: Unaffordable premiums

Lloyd Pudiwitr owns a TV repair shop in Bakersfield, Calif. He has seven full-time employees and one part-timer. For years, he paid half the premium for his employees' health coverage. But by the end of 1988, the premiums had become so high he could no longer afford to pay his share. "It's one of those things that could break you," he says. His employees now pay the entire cost of their coverage.

Like many small employers, he changed carriers every few years, searching for the lowest premiums. Two years ago Pudiwitr, who is 55, had a heart attack, and the wife of one of his employees, Ian Sutherland (pictured in background), had cancer surgery.

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from $272 to $543, and the premium for Sutherland doubled from $421 to $842.

Luckily, Sutherland turned 65 and became eligible for Medicare, but he still must pay $450 a month for his wife's coverage. Pudiwitr has a long way to go until Medicare pays his bills, and he doesn't know what he'll do when his premiums rise again. "It's almost to the point where I can't afford it. If it doubles again, there's no way I can pay $1000 a month for health insurance," he says. "I didn't have any idea this would happen to people."



profit, and they can increase their odds of success by insuring good risks who are unlikely to have health problems. Competition among carriers for the healthiest risks has become cutthroat.

In large businesses with many employees, it doesn't matter if some employees have serious medical conditions. The risk they pose can easily be spread among the healthy workers. But in a small group with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. So the rules for insuring workers in small businesses are more rigorous.

Insurers use a controversial scheme to insulate themselves from risk. They offer to insure employees in a small firm (usually those with fewer than 25 workers) at a "low-ball" premium for at least the first year. If members of the group experience costly health problems in the second and third years, the carrier tosses the firm into a pool with other groups whose health-care costs are high and jacks up its premiums as much as 200 percent.

By placing firms into several "rate tiers," insurance companies can bid for the healthiest groups with rock-bottom premiums. But employers and their employees who have had serious health problems are stuck with their present insurance carrier; they can't move to another because no other company is likely to take them at any premium. Worse, the present carrier may decide not to renew the group's coverage, forcing employers and employees to find other insurance. And that may be impossible.

No coverage for the sick

Companies insuring small groups require employees and their dependents to meet tough health requirements, just as they do for individuals buying policies on their own. No carrier wants to insure employees and dependents who have had heart attacks or cancer. They will either exclude them from the policy or decline to insure the group altogether. Sometimes a single employee with a serious disease is enough to earn a rejection slip for the whole group.

Increasingly, insurance companies are turning down people with far less serious health conditions than cancer or heart disease, excluding everyone except those in perfect or near-perfect health. "We don't want to buy a claim," is how one company official puts it.

Many people who become ill while they are working may find themselves without insurance when they leave the security of their employer's policy. Indeed, many are held hostage to their current job just to keep their insurance.

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns $19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to five weeks, she needs a lifesaving infusion of antibodies that costs about $2400.

The firm's Blue Cross policy has been paying most of the bills. But as a result of those expenses, the cost of coverage has risen sharply—both for the firm, which pays the premiums for its employees, and for the employees, who must pay the premiums for their dependents.

"When I was given my review, I was told I might look around to see if I can find another job," Turner says. "They intimated that if I did leave, it could lower the cost of their insurance."

If Turner leaves her job, it's unlikely her daughter will ever again have coverage. And there's no way she can pay for the monthly infusions herself. "Without the medicine, my daughter dies. That's the black and white of the situation," Turner says. *Continued*

Crisis: Locked in

Kay Nichols, a fitness counselor at a Gainesville, Fla., health club, is in the pink of health except for glaucoma, an eye disease that can cause blindness if not treated. Not long ago, her employer wanted to switch insurance carriers to take advantage of lower premiums. When the health club found another insurer, the agent told Nichols that she would not be covered, even though her glaucoma is under control.

Nichols looked into a conversion policy from her present company but found she would have to pay $6000 for six months of coverage for her family. She tried Blue Cross, but its policy would have excluded coverage for glaucoma.

When her employer learned of her plight, he decided to keep the current policy despite its higher premiums. "If the premiums get phenomenally high, they can't keep the policy just for me, and I understand that," Nichols says. At the same time, she realizes she has a problem that won't go away. "Maybe I don't want to stay with this company the rest of my life," she says. "It makes me worry."

Nichols is 38.

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NORTHERN DISCOMFORT

The Ills of the Canadian Health System

EDMUND F. HAISLMAIER

Charles Coleman was 63 years old when his doctors told him that, unless he underwent coronary bypass surgery, he might die. In the four months that followed his diagnosis, Coleman's surgery was postponed 11 times; doctors at Toronto's St. Michael's Hospital cited a bed shortage in the Intensive Care Unit (ICU) as the cause of the delays. At one point, Coleman waited in the hospital 13 days before being discharged without surgery.

Although the surgery was finally performed, members of Coleman's family said that the long ordeal had so weakened him that he had become "a broken man" who had lost his will to live. He died eight days after his surgery.

This sad case, although dramatic, is not remarkable in Canada, where the health care system has been fully nationalized for the past two decades. In a 1989 cover story entitled "Sick To Death," the Canadian news magazine *Maclean's* described Coleman's case, as well as numerous other examples of a national health care system in crisis. Dr. Phil Gold, then-chief physician of Montreal General Hospital, complained, "I'm living from hand to mouth and waiting for disaster each day....I don't know when someone will die for lack of a bed or the proper equipment."

Yet, in spite of its flaws, the Canadian system is the very model frequently proposed as a solution to the health care problems in the United States. Proponents of this view contend that the Canadian system provides access to health care for all its citizens at a lower cost than in the U.S., and with the same or better quality. Furthermore, they claim, a U.S. version of Canada's system could retain the freedom of choice currently enjoyed and valued by Americans, while hospitals and physicians would be free to practice medicine with less interference or oversight from government regulators than many providers face today.

Presented this way, it is perhaps no surprise that Canada's system looks quite attractive to many Americans. Indeed, it registers considerable support in U.S. public opinion polls, far exceeding support for the existing system. According to a recent *Wall Street Journal*/NBC News poll, 69 percent of voters polled supported a Canadian-style system, including 60 percent of conservatives and 62 percent of those with household incomes exceeding $50,000. Legislation now pending in Congress and several state legislatures would, if enacted, replicate the Canadian health system in the United States or in particular states. But in reality, the Canadian system is far less attractive than it appears at first glance.

Before examining why this is so, it is necessary to first dispel some basic misconceptions many in America hold about the Canadian system.

Similar Provincial Plans

To start with, the Canadian "national" health care system is not national in the sense of being funded or administered by a central government. The system is actually a collection of separate, although very similar, provincial systems. Each of Canada's 10 provinces and two territories administers its own universal health plan and pays for most of its costs. Historically, the role of the Canadian federal government primarily has been to provide partial financing of the provincial health systems and to set broad structural guidelines to which the provincial plans must adhere if they are to receive federal financial support.

Those national guidelines were developed over several decades, leading to the establishment of similar systems in all Canadian provinces by 1971. In 1984, the federal guidelines were revised and consolidated in the Canada Health Act, which forms the basis of the current system. Under this act, provincial health plans are eligible for partial federal funding if they meet the following five requirements:

Universality. The plan must cover all residents of the province under uniform terms and conditions. For new residents, the waiting period prior to entitlement must not exceed three months.

Portability. The plan must provide continuous coverage for residents who are temporarily absent from the province and for individuals who move to another province until they qualify for that province's plan.

EDMUND F. HAISLMAIER *is a health care policy analyst at The Heritage Foundation*

Comprehensiveness. The plan must cover all hospital and physician services deemed "medically necessary" by the federal government. Other items can be covered at the discretion of the provincial plan under terms set by the provincial government. Such discretionary items include: outpatient services provided by non-physician practitioners (such as basic dental and eye care, prescription drugs, physical therapy, and chiropractic services), and non-medically necessary services or amenities (such as cosmetic surgery or private hospital rooms).

Accessibility. The plan must provide all residents with reasonable access to care without financial barriers, such as out-of-pocket costs, and provide reasonable levels of compensation to physicians.

Public administration. The plan must be operated and administered by a nonprofit, public authority accountable to the provincial government.

Prior to the 1984 act, provincial plans could charge patients user fees for services, although these were generally quite low and did not cover actual costs. Moreover, doctors were permitted to charge patients more than the fixed reimbursements provided by the provincial plans, a practice known as "extra billing." In 1983, extra billing was estimated at CN$100 million, or 0.3 percent of Canadian health spending; this figure is equal to approximately CN$4.00 per capita. The act effectively ended such practices by stipulating that federal payments to provincial plans would be reduced by the total amount of any user fees and extra billing paid by patients for the federally required basic services. Since 1987, all provinces have eliminated user fees, and extra billing is illegal throughout Canada for the basic services. Provincial plans, however, may still set user fees, or limit coverage, for any additional services they cover.

Doctors Self-Employed

While the Canadian federal and provincial governments control the financing of health care, they do not directly control or manage the delivery system. Most physicians are self-employed and are paid on a fee-for-service basis according to fee schedules periodically negotiated between the provincial governments and physicians' associations.

Similarly, most Canadian hospitals are in private hands, although virtually all of them are operated on a nonprofit basis. Out of a total of 1,243 hospitals, only 61 (or fewer than 5 percent) are operated on a for-profit basis by private owners. These do not participate in the provincial plans, and as a result their patients must pay all costs directly out-of-pocket. Most of these hospitals are really nursing homes. Another 49 hospitals are owned and operated directly by the federal government to serve patients in programs such as those for veterans, defense personnel, immigrants, and prison inmates.

The remaining 1,133 hospitals are "public," meaning that they operate on a nonprofit basis, participate in their respective provincial health plans, and serve the general public. Of these, 57 percent are privately owned by either religious orders or secular voluntary organizations, with the remaining 43 percent owned by provincial or municipal governments.

The operating expenses of all public hospitals are financed by the provincial plans on the basis of "global budgets." This means that each hospital negotiates each year with the provincial plan for its total (global) operating budget for the coming year. The money then is disbursed to the hospital in periodic, lump-sum installments throughout the year.

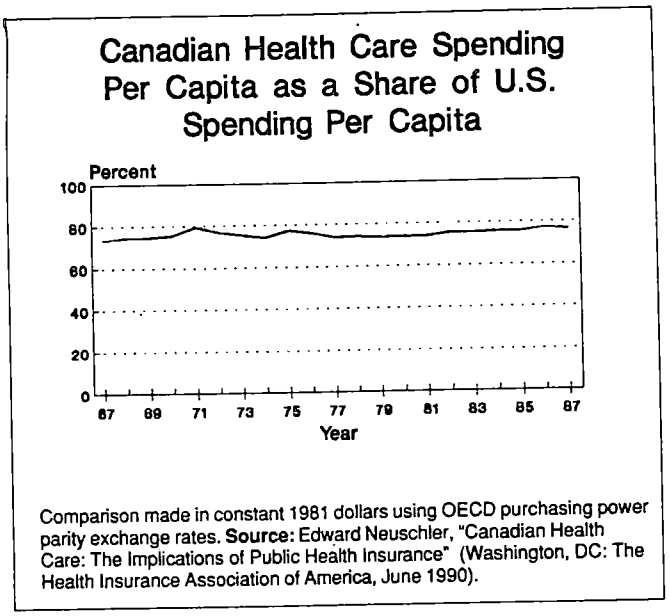
Most of a hospital's capital budget, used for acquiring new equipment or facilities or upgrading existing ones, also is provided by the provincial government. This budget is kept separate from the hospital's operating budget. While hospitals may, and usually do, raise private funds for capital expansions through bonds or donations, those funds are controlled indirectly by the provincial governments as well. If the authorities do not agree with a planned capital outlay, they will refuse to provide the additional funds in the hospital's operating budget needed to staff or operate the new facilities or equipment. Thus, in practice, the provincial plans use the operating budget to limit the ability of hospitals to expand or offer new services. By exercising their "power of the purse" in these ways, the provincial governments seek to control total health spending. In the delivery of health care, however, doctors and hospitals still retain considerable discretion to run their facilities and treat their patients as they judge best.

The Canadian system appears to provide universal health insurance coverage at a lower cost than our present system, which leaves 31 million Americans uninsured.

Finally, the Canadian system is not, as many in the United States assume, universal in the sense that it covers all medical care or health spending. Nor, in fact, are nationalized health systems in other countries universal in this sense either. Of total health care spending in the United States, 42 percent is funded through federal, state, and local governments. The share of Canada's health spending funded through its federal and provincial governments is 74 percent. This point is worth noting because virtually all proposals to replicate the Canadian system here would, in fact, significantly exceed the scope of the current Canadian system, entailing government funding of 90 percent or more of U.S. health spending.

Mythology of Cost Control

What its U.S. proponents find most attractive about the Canadian system is that it appears to provide universal health insurance coverage at a lower cost than our present system, which leaves 31 million Americans uninsured.



Comparison made in constant 1981 dollars using OECD purchasing power parity exchange rates. **Source:** Edward Neuschler, "Canadian Health Care: The Implications of Public Health Insurance" (Washington, DC: The Health Insurance Association of America, June 1990).

Canada's net per-capita health spending remained at 75 percent of America's both before and after the start of Canada's national health system in 1971.

In the early 1960s, before Canada moved to a national system, it was spending a slightly higher percentage of its GNP on health care than was the United States, roughly 6 percent versus 5.5 percent, respectively. After 1971, however, when the main elements of Canada's system were introduced in all provinces, costs began to diverge, with Canada spending considerably less of its GNP on health than its southern neighbor. In 1989 U.S. health care spending was 12 percent of its GNP. In contrast, Canada's health care spending was only 9 percent of its GNP.

The simple conclusion, drawn countless times from these data by experts and laymen alike, is that Canada significantly limited the growth of health care spending once the government took control of health care financing. This leads to the assertion that the United States would achieve similar results if it adopted a Canadian-style system. In fact, however, this simplistic comparison of relative health spending as a percentage of GNP is misleading, and the popular conclusions drawn from it are invalid.

A closer examination of health care spending in both countries between 1967 and 1987, the most recent 20-year period for which data are available, shows why this is so. Between 1967 and 1987, real (inflation-adjusted) per capita health care spending increased at an average annual rate of 4.58 percent in Canada, versus 4.38 percent in the United States (both figures are in local currency). But GNP growth was, on the average, higher in Canada than in the United States during the same period. Between 1967 and 1987, again measured in local currency, Canada's real per-capita GNP grew 74 percent, while the real growth in U.S. per-capita GNP was only 38 percent. Canada, in short, has done no better than the United States in controlling the growth of health care costs, but our northern neighbor's health care/GNP ratio has remained lower because of its more rapidly rising GNP level.

When figures for both countries' real per capita health spending are converted into the same currency, they show that Canada has consistently spent about 75 percent of what the United States spends on health care, both before and after the introduction of universal government funding in Canada. Why this disparity exists is a matter of some speculation. What is clear, however, is that the introduction of a government-financed health system in Canada generated no measurable change in the real rates of Canadian health care spending relative to that in America.

Perverse Results

While Canadian federal and provincial governments have failed to control the growth of health care spending by any meaningful measure, their attempts to do so have generated perverse results. This is due to how the system pays doctors and hospitals.

Ironically, the same payment methods that cause the problems are viewed by many as one of the system's most attractive features because of the freedom they allow both patients and providers. Patients may choose from any doctor or hospital participating in the provincial plan. Although doctors and hospitals must accept government fees or budgets, they are free to manage their facilities and practice medicine as they see fit, without the detailed oversight and stifling bureaucracy that characterizes the U.S. Medicare, Medicaid, and private insurance systems, or even some other nationalized systems.

In contrast to some other nationalized systems that pay doctors flat salaries or a fixed annual amount per patient, a Canadian doctor is paid a fee for each service provided, with the schedule of fees negotiated annually by the provincial government and the provincial medical association.

The problem, however, is that in any fee-for-service system where patients do not purchase care directly, or even buy their own health insurance, there is no financial reason for them to question physician decisions. This leaves doctors free to compensate for reduced government-set fees by increasing the volume of services they provide. According to a recent article in the Massachusetts Institute of Technology's *Technology Review*, Canadian provinces cut physician fees by 18 percent between 1972 and 1984, but doctors' total billing claims rose by 17 percent during the same period. When Quebec froze medical fees from 1972 to 1976, causing a drop of 9 percent in their real-dollar value, doctors increased their billings by 8.3 percent. Similarly, in spite of a 1984 freeze on medical fees in Alberta, the province's doctors increased their incomes by 12 percent that year. "Hit with a fee cut, doctors simply see more patients and provide more services," the MIT report concluded. Most of these services are unnecessary and simply push up health care spending needlessly.

Obsolete Equipment

Confronted with this new problem, at least one province, Quebec, has responded by placing limits on the amount it will pay individual doctors each year—strongly discouraging them from providing additional

treatments. But it is hard to see how this differs, in practice, from simply making doctors salaried employees of the government.

Other Canadian provinces are now either considering or introducing similar changes. Some are also looking at adopting U.S.-style utilization review and control methods. But each of these trends will increase bureaucracy and drastically curb the vaunted clinical freedom of Canadian doctors.

Canadian doctors and hospitals see their clinical freedom restricted in other ways, particularly as a result of global budgeting for hospitals and government controls over hospital spending on capital improvements. Many Canadian hospitals were built in the 1950s and 1960s. But since the nationwide health system was put into place in 1971, hospitals have found it increasingly difficult to obtain the funding they need to replace obsolete or worn-out equipment or facilities. In essence, Canada's hospitals have been living off their existing capital for 20 years, and more of them are gradually exhibiting the obsolescence and decay found in many British National Health Service hospitals.

The provincial governments also sharply restrict the availability of medical equipment outside of hospitals, forcing doctors to conduct most procedures in a hospital, where they can be both more closely monitored and controlled. This practice produces perverse results as well. "The dramatic shift to outpatient diagnostic testing and outpatient surgery that has taken place in the United States has not been replicated yet in Canada," observed Ed Neuschler, of the Health Insurance Association of America, in his study of the Canadian system. "For example, all Canadian computerized tomography (CT) scanners are located in hospitals and, in Ontario, this has been made a legal requirement. Keeping major medical procedures in hospitals, which are under their direct budget authority, allows provinces to better manage total costs by controlling supply." In other words, to control physician practice patterns and patient demand, Canada forgoes the potential cost savings and quality improvements these new outpatient technologies would otherwise generate in a true free market.

These practices also have an adverse effect on patient care. For example, magnetic resonance imaging (MRI) machinery is now widely used in the United States in the treatment of joint, spinal, and neurological disorders; over 2,000 MRI machines exist in U.S. hospitals, clinics, and diagnostic centers. But Canada possesses only 15 MRI scanners, and all of these are located in hospitals, making these tests much more difficult to obtain. This calls for tough decisions on the part of doctors, who must decide what constitutes a priority case for MRI screening. "A person with a quickly progressive paralysis qualifies as an emergency and promptly obtains a spinal scan to determine the source of the problem. But patients awaiting operations for brain tumors or confined to bed by ruptured disks are considered to be merely urgent and wait one to six weeks," a recent *New York Times* article reported. One physician at Jewish General Hospital in Montreal put the dilemma in graphically personal terms: "These people are watched very carefully, but imagine being 30 years old and sitting around with a brain tumor growing, even very slowly, in your head."

The most serious consequence of hospital global budgeting is the outright denial of medical care it encourages. To stay within budgets, hospitals have resorted to closing beds for part of the year or limiting the number of operations they perform. Yet at the same time, while Canada has only a 5.2 percent higher rate of hospital admissions than does the United States, Canadian hospitals, compared with their U.S. counterparts, have: 29 percent more beds per 1,000 population; a 27 percent higher bed occupancy rate; a 52 percent longer average length of stay rate; and, 63 percent more patient days per 1,000 population.

Longer Stays

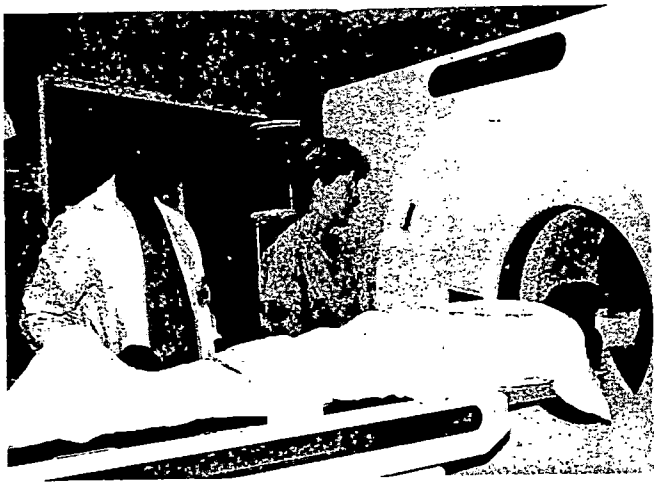
What are all these people doing in hospitals? To some extent, the lack of alternative outpatient care in Canada forces many individuals to enter hospitals for services that would be provided in a doctor's office or clinic in the United States. But more significantly, hospital administrators, under a global budget, have a strong incentive to keep patients longer rather than serving more patients with shorter hospital stays.

Imagine you are the administrator of a U.S. hospital. The more beds you fill, the more revenue you receive, which means the more profit you generate. If the hospital is a for-profit one, some of that profit will go to expanding services, and some will go to stockholders. If it is a nonprofit hospital, all the extra funds can go to expanding services. In either case, your board of directors will be pleased.

"The best way to stretch a fixed hospital budget is by keeping sick people out and healthy people in."

However, the people paying the bills (usually the insurance companies) want you to treat patients quickly and then, as soon as possible, send them home or elsewhere to recuperate in a less costly setting. These conflicting pressures push you to make the hospital a more efficient treatment center with short patient stays and a high turnover rate. But now imagine that, instead, you are the administrator of a Canadian hospital. Your budget is fixed by the government, and treating more patients won't bring you any more revenue. Instead, it will simply eat up your budget. Furthermore, treating patients with costly illnesses will consume your budget even faster.

You certainly won't look like a competent manager to your superiors if you use up your entire budget before the end of the year. On the other hand, if you don't treat any patients, you won't use up your budget—but you won't look competent either. How do you respond to this very different set of conflicting pressures?



Canada possesses only 15 MRI scanners, which are widely used in the United States for diagnosing joint, spinal, and neurological disorders.

To start with, you know that when patients enter a hospital, regardless of their condition, most of the cost of treating them comes from providing expensive medical services in the first day or so. After that, they use fewer medical services and more of the hospital's much cheaper "hotel" services. So the answer presents itself. Avoid admitting patients who are costly to treat, unless of course it's a life-threatening emergency, in which case turning them away is going to look very bad indeed. Instead, admit less costly patients, treat them, and then keep them in the hospital. As one doctor put it, "The best way to stretch a fixed hospital budget is by keeping sick people out and healthy people in."

Such practices inevitably produce both full hospitals and long waiting lists for major medical care. If complaints are then raised about waiting lists to enter the hospital, the administrator can credibly claim that he does not have enough funds to meet the demand. He then will either receive more money from the provincial government, or he will have effectively bucked the problem up the chain of command to his political superiors. The administrator wins either way. Indeed, this practice of lengthening patients' stays is so common that Canadians have dubbed such long-stay patients "bed blockers," meaning they are blocking someone else's access to a hospital bed.

Maple Leaf Drag

As with any nationalized health system, when unlimited demands for perceived "free" care collide with limited government budgets, shortages result and more people must take a number and wait for treatment. The resulting problems and horror stories have provided much grist for the press.

The same *Maclean's* article that related the story of heart patient Charles Coleman also reported: "Hospitals in some cities have had to institute unusual, and sometimes humiliating, economic measures. Patients in the maternity ward of Toronto's North York General Hospital are required to bring in their own pillows, while elderly patients in some Montreal hospitals are being kept in diapers because nurses do not have time to help them go to a bathroom." At the same time, at New Brunswick's Moncton Hospital, "some patients are kept in hallways and even closets, while a total of 2,300 people were on the waiting list for surgery last month."

In April 1989, one Ontario paper reported, "There are currently 1,600 people in Ontario waiting for heart surgery and the list is steadily increasing." The same month, another Ontario paper published the news that, "Kitchener-Waterloo Hospital will be closing at least 43 beds, laying off or cutting back the hours of at least 70 staff members, capping the hemodialysis program, and discontinuing lens implant procedures at the hospital."

From the *Winnipeg Free Press* came the report in July 1989 that, "Doctors and nurses at Brandon General Hospital lashed out yesterday at bed closings that have left 91 patients, including cancer victims, waiting up to six weeks for urgent surgery. Most of the patients have cancer of the breast, large bowel, or lungs, chief of staff Dr. Michael Taylor said. He blamed the funding woes and bed closings on a Health Department policy introduced by the former government that forbids deficit-financing and forces hospitals to balance their budgets."

On September 14, 1989, the *Toronto Sun* reported, "The Princess Margaret Hospital has announced it won't accept new cancer patients requiring radiation treatment for a six-week period starting September 30 to clear up a 300-patient backlog." Last year the *Edmonton Journal* stated, "The only hospital doing cardiovascular surgery in northern Alberta now has 210 adults and children on its waiting list. The average wait is six months, although some people have been waiting as long as a year, said a hospital spokesman."

The U.S. political structure is fundamentally unsuited to effectively administering a national health system like that in Canada.

Yet in spite of these problems, the system remains extremely popular with the general Canadian public. Indeed, opinion polls show that most Canadians believe their system is without rival. But increasingly that popularity is derived not from any inherent virtues of the system, but from the inevitable calculus of political economics. As in other nationalized systems where money is eliminated as the means of allocating goods and services, the Canadian system increasingly allocates health resources on the basis of votes, not on the basis of need. For the lucky majority who are reasonably healthy, they will continue to find ready access to routine, low-cost medical services. But for the unfortunate minority with serious conditions, they will increasingly be expected to take a number and wait.

$190 Billion in New Taxes

If all of this is not enough to dissuade U.S. policymakers from instituting a Canadian-type system, the projected costs definitely should be. While several detailed analyses of the cost of adopting a Canadian-type system in the United States have recently been conducted, they only confirm what quick, back-of-the-envelope calculations yield. Present U.S. health spending is over $600 billion per year, of which the federal, state, and local governments account for 42 percent, or roughly $250 billion. Thus, expanding the total government share to the 74 percent found in Canada would necessitate about $190 billion per year in new government spending. Expanding the government share to around 90 percent or more, as would occur under most pending legislation to adopt the Canadian system, would push total new government spending into the $300-billion-per-year range.

Economists Gary and Aldonna Robbins have estimated that funding such a total health care nationalization program would require either: Increasing the combined employer-employee payroll tax from its current rate of 15 percent to 29 percent; raising income tax rates across the board by 14 percent; or, imposing a new national sales tax of 10 percent.

Furthermore, the U.S. political structure is fundamentally unsuited to effectively administering a national health system like that in Canada. Unlike other countries with nationalized systems, the United States does not have a parliamentary system of government. The U.S. system not only separates the executive and legislative functions, but even within the legislative arena congressmen and state legislators more closely represent the narrower interests of their constituents, have much more power to alter legislation, and are much less subject to party discipline than are their parliamentary colleagues in other countries.

Because of these significant political differences, any national health system in America likely would quickly degenerate into pork-barrel politicking and legislative micro-management. Indeed, one does not have to look to obsolete military bases, farm subsidies, public works programs, or dubious research projects to find examples. There is already one graphic example in the U.S. health care system of what would happen nationally with a Canadian-style system: namely, the medical system run by the Department of Veterans Affairs. That system labors under chronic budget problems, and constant restrictions and special-interest requirements imposed by Congress. In fact, congressional interventions have kept any obsolete V.A. hospitals from being closed over the past 26 years.

Alternatives to the Canadian Plan

There is a lesson in the Canadian experience that Americans should take to heart.

In reforming our own system, we should avoid confusing means with ends. All the attention focused on the uninsured in the United States has led many to seek universal health insurance coverage through a nationalized system. Yet the real goal should be to provide all Americans with adequate medical care. Health insurance is only one of several means of achieving that goal, and many times it is not the best means.

Rather than instituting a government-run system of universal health insurance, Americans should pursue reforms designed to ensure that all citizens have access to adequate medical care. Such reforms should have two fundamental objectives:

First, to empower consumers by giving workers and their families direct control over the money used to purchase their medical care and insurance, thus unleashing market forces and consumer choice to control health care costs and bring efficiency to the system.

Second, to restructure existing health care tax policies and government programs to provide the poorer and less healthy members of society with the extra purchasing power they need to obtain necessary medical care and insurance in a freely functioning market.

Pursuing reforms based on these principles offers the best hope for America to create not only a better and less expensive health system, but also a system that achieves the goal that has eluded Canada: affordable access to medical care for all its citizens.

Indeed, perhaps the ultimate irony of the Canadian system is that it is evolving into what Canadians sought to avoid: a two-tiered system. While all Canadians have access to health insurance, fewer of them are receiving access to needed medical care.

Canada's system serves well the majority who are reasonably healthy. But people with serious conditions will increasingly be expected to take a number and wait.

As the problems in their health care system grow and deepen over the coming decades, Canadians may eventually find themselves turning toward market-based reforms of the kind now being instituted in the older national health systems of Britain and Sweden.

Then again, the crisis may be nearer at hand. As Ontario kidney specialist Adam Linton told the *New York Times* in April, "We have not yet had to kill anyone by not providing dialysis or a transplant, but the issue is at a flash point."

Canadian Health Care Is a Model for Disaster

The Americas

By Michael Walker

VANCOUVER—An important issue in the current debate over Canada's constitution is the maintenance of "national standards" in the social programs which have become a hallmark of Canadian citizenship—at least since 1971 when Canada's Medicare came into full effect. In 1991, against the backdrop of an impending health-care crisis, it may be easy for American observers to look enviably at the Canadian system. Certainly the mythology associated with our health-care system and other national programs is important in synthesizing the Canadian identity and sustaining the notion that we in Canada have achieved the kinder and gentler society about which U.S. citizens can only dream.

At the moment the federal Canada Health Act ties federal funding for Medicare to a set of rules including prohibition of any user fees or coinsurance payments. Provincial governments have fought these provisions which have become part of the constitutional debate concerning provincial autonomy. Medicare boosters fear that this decentralization of power will eventually lead to fragmentation of and, horrors, the "Americanization" of the Canadian health-care system. They, including the socialist parties that are likely to rule in three provinces as a result of elections this month, want the new constitution to centralize control over health care and everything else.

The notion that the U.S. mode of health care poses even a tiny threat to Canadian practice will come as a surprise to those who have been touting the Canadian system as the solution for the U.S.'s health-care woes. Moreover, it is ironic that the source of the Canadian problem with medicare—monolithic, centralized control—is seen south of the Canadian border as the source of great savings. In fact, according to results presented in the New England Journal of Medicine and graphically illustrated in the PBS special, "Borderline Medicine," half the difference between the cost of health care in Canada and in the U.S. is the cost of administering the two health-care systems.

Canada, with its single provider, has only one paper trail associated with a patient's meandering through the medical maze. The patient has no invoices to check, no bothersome forms to fill out and is generally not involved in the financial process associated with the diagnosis and treatment of his illness. The physician is paid on the basis of a single report to the health department or medical services bureau and the hospital receives its payment in the form of a global budget for the year. The net result is that in Canada only 0.1% of the national income is used to administer the health-care system. In the U.S., on the other hand, 0.6% of the national income is spent to administer the system and another 0.63% is expended by the physicians and hospitals in complying with the requirements of insurers.

The solution is clear, tout critics of the U.S. system. Simply eliminate all of the wasteful paper-shuffling and the 37 million U.S. citizens who are currently without insurance can be covered. They further assert that the wasteful paper-shuffling results from competition among alternative suppliers, which serves no useful purpose. It is the multiplicity of suppliers that is at the root of the problem. Eliminate the duplication and you eliminate the cost.

Attentive readers will recognize this argument from another Canadian export, John Kenneth Galbraith. They may wish to test its validity by imagining all the waste and duplication that could be eliminated from the markets for automobiles, breakfast cereals, bread, etc. "Okay," Galbraithians concede, "but health care is different."

Well, maybe it is. But duplication has the indisputable benefit of ensuring that if one source of supply is withdrawn, others are there to replace it. As we have been discovering in Canada, this concern for continuity is not a theoretical proposition. As the monopoly supplier of health-care resources, the government is also the effective monopoly employer of health-care personnel. Accordingly, it periodically must negotiate collective agreements with the almost entirely unionized health-care sector, including fee schedules with physicians and other providers of covered services.

Some times these negotiations go smoothly and there are no interruptions of health-care services. With increasing frequency, however, the negotiations do not go smoothly—in part because the governments involved are finding it very difficult to keep the lid on health-care costs without putting them in direct conflict with health-care providers and support staffs.

It was estimated that 12 to 20 patients in the queue had died waiting for operations.

The extent of the friction and its rate of increase can be measured by the number of days health-care workers lose due to strikes and lockouts. Recent compilations by the Fraser Institute show that whereas there were no strikes and no days lost in the first five years of our Medicare program, there were an average of 14,000 per year in the second five years ending in 1980. By 1985, this had more than doubled to 31,920 person-days lost per year. In the most recent five-year period, the average has been 174,518 person-days lost per year.

Buried in these figures is the 17-day nurses strike which effectively shut down the health-care system in the province of British Colombia during 1989. And one particular case from that strike, of 35-year old insulation worker George Yetman, reveals the human tragedy of this system-wide friction.

Mr. Yetman had been referred for quadruple bypass surgery in March of 1989. He sat on the waiting list for three months, only to find that others with "emergent conditions" joined the waiting list ahead of him as the nurses strike closed the already overwhelmed cardiac surgery capacity. During the slowdown and strike, Mr. Yetman watched the list grow from 400 to 800 before arranging to have his bypass surgery in Detroit, Mich. Indeed, according to an article in the August 28 edition of the Journal of the American Medical Association, the "solution" adopted by the B.C. government to clear up the bottleneck caused by the strike was to arrange for 200 bypass surgeries to be done in Seattle, Washington. Although Mr. Yetman was operated on in the U.S. and survived, the Provincial Cardiac Society estimated that 12 to 20 patients in the queue had died waiting.

The current constitutional debate in Canada reflects that fact that Canadians want a more decentralized, competitive federation because the current centrally controlled system is too brittle and insufficiently responsive to the need for economic rationality or the differing needs of the provinces. The developments in the health-care sector are illustrative of the unanticipated problems centralization can bring. It is questionable under the circumstances whether the U.S. should look to Canada for solutions to health-care problems.

Mr. Walker is executive director of the Vancouver-based Fraser Institute.

Study Finds Rx for U.S. In Canada Health Plan

In Decade, Savings Calculated in Trillions

By Spencer Rich
Washington Post Staff Writer

The United States would save $241 billion on health-care costs the first year and $4.2 trillion over the next decade if it switched to a Canadian-style national health insurance system, according to an economic study released yesterday.

The savings over the decade would be about equal to the entire U.S. economy in 1991, the study found. Business firms would be

IDEAS & FINDINGS

among the big winners, the study found, because their health-insurance outlays would be less.

The study, the latest entry in the growing debate over how to restructure the U.S. health system to provide insurance for all and cut costs, was commissioned by the Robert Wood Johnson Foundation and carried out by the Economic and Social Research Institute, headed by health economist Jack Meyer.

"This report challenged us to determine whether the benefits of our current health care financing justify its sharply rising costs," said Meyer. "Relentless growth in health care spending is increasingly claiming resources that could be used to meet other vital human needs."

Meyer and his colleagues looked at potential savings under a scenario that called for the United States to use a Canadian-style system and spend no more than 8.7 percent of gross domestic product, Canada's current figure. Under "business as usual," they calculated the current U.S. system, which costs 12.8 percent of gross domestic product, would rise to 17.5 percent by the year 2000.

Meyer and his colleagues, Sharon Silow-Carroll and Sean Sullivan, assumed that the government would reduce costs by cutting administrative and paperwork costs as a result of having a single insurer, holding down the use of amenities like private and semi-private rooms, and slowing up the addition of new machinery and technology. About $28 billion in savings would come from reducing doctor fees by about a quarter to get them down to the levels in place in Canada.

If the current system were to continue in effect and health costs rise to 17.5 percent of gross domestic product by the year 2000, health costs in that year would be $1.96 trillion in nominal dollars (not adjusted for inflation), they calculated.

But if a Canadian-style national health insuance system spending 8.7 percent of GDP annually were put into effect, the costs in the year 2000 in nominal dollars would be just under $1 trillion ($972 billion), instead, they said.

Over the decade of 1991 to 2000, the shift to a Canadian-style system would result in savings of $5.5 trillion in dollars not adjusted for inflation, which would be $4.2 trillion in inflation-adjusted dollars.

The study concluded that business firms would save about $136 billion a year in gross health insurance premiums and similar health outlays for their workers, but much of that would be eaten up by taxes on added profits, and addition of nonhealth benefits for workers. Even so, it calculated, employers' net share of total savings would be $512 billion in real 1991 dollars over the decade.

Under a second scenario, which the authors said is probably more achievable, the study calculated how much would be saved if it were assumed that the current system would increase spending to 16.1 percent of gross domestic product over the decade and that a Canadian-type system adapted to U.S. needs would cost 13.1 percent of the gross domestic product.

Under this scenario, savings would be $1.3 trillion in nominal dollars over the decade, or $1 trillion in 1991 dollars for the 10-year period.

The study, the authors wrote, "shows that the potential short-term and long-term financial savings from containing health care spending are great. And it challenges us to determine the benefits from continuing along a path of unrestricted spending growth, and decide whether they are worth the cost."

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July 15, 1989

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LENGTH: 5061 words

HEADLINE: Taking Care of Canada

SERIES: This is the first of two articles on Canada's health care system. The second article will analyze the issue of whether elements of Canada's system might be adopted by the United States.

BYLINE: BY JULIE KOSTERLITZ

DATELINE: TORONTO

HIGHLIGHT:

As America agonizes about soaring medical costs and the millions who lack health insurance, Canada's system illustrates the prospects and pitfalls of universal coverage.

BODY:

Canadians can't help betraying their amusement. All of a sudden, a nation that has played permanent understudy to its self-absorbed neighbor to the south is in the limelight. Congressional delegations, economists and journalists are flocking north to look at its health care system.

William L. Roper, the White House deputy assistant for domestic policy, was here, Canadians tell you. So were Reps. Fortney H. (Pete) Stark, D-Calif., and Willis D. Gradison Jr., R-Ohio, the chairman and ranking minority member of the Ways and Means Subcommittee on Health. The American Association of Retired Persons set representatives, and just the other day, it was The New York Times and Sen. Dave Durenberger, R-Minn.

For the benefit of Americans who can't make the trip, some Canadians find themselves subject to command performances at conferences and hearings in Washington. "At first, Mohammed came to the mountain," joked Martin Barkin, Ontario's deputy minister of health. "Now, they want the mountain to go to Mohammed."

The Canadian system isn't new: The basics have been in place for about 20 years. Nor is the American flirtation with national health insurance new; it has been going on for at least that long. "Interest in Canada seems to come and go every five years," said Graham W. S. Scott, chairman of an Ontario health policy group.

What has tuned the spotlight on Canada this time is a mounting sense of crisis in the American health care system. A large and growing number of Americans lack health insurance -- the estimates have ranged from 31 million-37 million. And the federal government and, increasingly, big business, worry that galloping health care costs could break the bank.

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Canada, by contrast, not only offers all of its 25 million citizens comprehensive health insurance, but it does so at a far lower cost than the United States pays. In 1987, Canada spent 8.6 per cent of its gross national product (GNP) on health care; the United States spent about 11.2 per cent. Moreover, life expectancy and other key health indicators look pretty similar in the two countries. Actually, Canada does better than the United States in certain areas -- it has lower infant mortality rates, for example.

What makes all this tough to ignore is that this is a country not too dissimilar from our own. There are, of course, important social and political differences. But in many economic and cultural aspects, as well as in demographic and medical trends, they are close enough so that -- if you somehow forgot that Canada has its Francophones and that its Anglophones say "aboot" when they mean "about" -- you could, for a moment, forget you'd left home.

Inevitably, some American policy makers are asking how Canada makes its health care system work -- and whether a similar system would work in the United States. Congress already is starting to move on a proposal to change medicare payments to physicians by using cost controls loosely based on the methods of some of Canada's 10 provinces.

Not all Americans gaze north admiringly, however: Organized medicine looks askance at the controls placed on doctors and hospitals and has reacted sharply to the prospect of Canadian-style reforms in medicare. The American Medical Association (AMA) has launched a campaign to call attention to shortfalls in Canada's system, replete with newspaper advertisements and prepared remarks for Members of Congress to read into the Congressional Record. Rep. Butler Derrick, D-S.C., was one of several who sided with the AMA's view, telling his colleagues on June 20 that Canada's system has brought "growing waits for necessary surgery, degrading conditions for elderly hospital patients and an intrusion into the physician-patient relationship."

The conservative Heritage Foundation in Washington sent journalists a copy of a cover story in the Canadian newsweekly Maclean's on 63-year-old Charles Coleman, who died shortly after a heart operation in a Toronto hospital; the operation had been postponed 11 times. Stuart M. Butler, Heritage's director of domestic policy studies, wrote that the lesson from Canada is that government-run systems result in "diminished and rationed health care resources."

"Canadian-style" medical care thus means, to some Americans, an equitable and economical system, but to others, a welfare state run amok.

ACCEPTING LIMITS

Seen up close, the Canadian system is a good deal more complicated than either description would imply. To begin with, Canada's is a joint federal-provincial system that varies greatly by province. For another, it is, like the U.S. system, accommodating to an era of fiscal austerity.

How well the system functions depends, not surprisingly, on whom you talk to. Nevertheless, from more than a dozen interviews with government officials, physicians and hospital administrators, and talks with consumers in two provinces -- Ontario, which is, in many respects, representative of trends throughout Canada, and Quebec, considered by many to be on the cutting edge of

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health care reforms -- certain themes emerge:

* Canada has decided to ration medical care according to need rather than by income or work status, as the United States has done by default.

* Universal coverage is a widely cherished and politically untouchable feature of the health care system here.

* The presence of a sole payer for health care, the government, is key to the country's ability to restrain cost growth.

The government has held down the rise in health care costs by restricting doctors' fees and the availability of health care providers and some services, institutions and high technology medical equipment. Because there's only on payer, the system spend substantially less on administration and advertising than the U.S. health care system spends.

The system doesn't always function smoothly; nor does the reality always match the rhetoric. Rationing according to need, for example, is anything but a science, and suspected failures -- especially fatal ones -- make instant headlines. And even though a government monopsony may be an effective agent of cost control, it can and has caused considerable rancor among physicians in some areas.

"Right now you have a bitter profession and a government that's indifferent to out bitterness," said Ted Boadway, director of health policy for the Ontario Medical Association (OMA).

Indeed, fiscal austerity by the Canadian federal government and some provincial governments and rising health care costs have produces a lot of finger-pointing. Left-wing critics, health economists and provincial officials tend to blame doctors for providing too many unneeded services and resisting change. Doctors blame "an entitlement mentality" that, they say, leads to public overuse of the system. Doctors also accuse government of making politically popular but economically untenable promises and then scapegoating doctors and hospitals when the promises can't be kept.

Even so, all parties respond to the notion of limits with a degree of cooperation and foresight that is unusual by U.S. standards.

"We take the approach that we're all in this together," said Ruth L. Collins-Nakai, a pediatric cardiologist in Edmonton, Alberta, and a past president of Alberta Medical Association who serves on a new provincial task force on the future of health care. "Parts of the health care system fighting amongst themselves is not going to solve the problems. "And Ontario's Barkin said, "There's almost a consensus on the direction changes should take between government, providers and citizens."

Roughly, the new conventional wisdom is that the bottlenecks in the system aren't caused by a shortage of money but by an inappropriate allocation of resources to high-tech medicine and institutions. Better accounting and more research are needed to track how money is spent and what results it gets, the thinking goes, and there's a shift in emphasis -- from state-of-the-art medical and institutional care of the sick and injured to disease prevention and social welfare, economic and environmental policy. There's also talk of more

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community involvement in health care decisions and better public education on the costs and consequences of health choices.

If the research and cost-accounting part of this strategy parallels, and perhaps copies, American thinking, the "alternative health strategies' part may sound vague and idealistic to American ears. But Canadians insists that such an integrated approach is both tangible and vital, and many of the provinces have set up high-level commissions that are translating that approach into specific plans for the future.

Whether such changes can alleviate glitches in the system is anyone's guess. But given the extreme popularity of their universal, tax-financed health care, Canadian policy makers would rather face up to tough choices about how much care can be provided than restrict anyone's access to care. During consideration of Canada's free-trade agreement with the United States last year, when Canadians briefly and mistakenly thought their health care system might have to be dismantled, opinion polls showed a whopping swing against the agreement.

Americans shrink from the notion that care must be rationed; Canadians don't. It's not a questions of whether either country must ration, they say, but rather how it is done. Canadians aren't shy about telling you that for all its shortcomings, their system represents the higher road.

"In Canada, when they thought one person did not get cardiac surgery in a timely way, that's front-page news," Barkin said. "In the U.S., when 37 million people don't get care, that's a small column in the back of your newspapers. Today's [newspaper] tells me you're even picking and choosing which ambulances you'll receive at an emergency department and which you'll send off somewhere else, like a scene out of Franz Kafka."

CONTROLLING COSTS

It all started in the western province of Saskatchewan just after World War II. After federal-provincial discussions of a possible national health insurance system went nowhere, that province in 1946 decided to forge ahead on it own, offering province-wide universal hospital insurance. Three years later, British Columbia and Alberta followed suit. In 1957, the federal parliament passed a law that made possible federal contributions to such plans, and by 1961, all provinces had qualifying plans.

Saskatchewan was the standard-bearer again with outpatient medical care, introducing the first universal medical care insurance program in 1962. Once again, the federal government picked up on the innovation, agreeing in 1968 to share costs for such programs. By 1972, all provinces had qualifying plans. "There was a certain social conscience that said, 'Gee, if they [another province] can do it, how can we not do it?'" said S. Vickery Stoughton, an American who is president of the Toronto Hospital Corp., which runs Toronto General Hospital and Western Toronto Hospital.

Under the federal-provincial system, the federal government sets basic standards, contributes about 37.4 per cent of the funds for the system and leaves the rest of the financing and decision making to the provinces. The federal standards hold that provincial plans must cover all essential medical service, encompass everyone, make services reasonably accessible and be portable -- that is, cover Canadians when they travel or move.

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Those features have endeared the system to Canadians. But it is the system's apparently superior ability to control cost that has riveted U.S. attention. In the mid-1960s, shortly after Canada's universal hospital insurance program got underway, both nations spent about 6 per cent of GNP on health care. In the two decades since, Canada's health care costs have risen by only about 3 percentage points as a share of GNP, while American expenditures as a percentage of GNP have nearly doubled, according to the Organization for Economic Cooperation and Development (OECD).

And here's another set of figures that has caught America's interest: In 1986, the United States was spending $ 1,926 per person for health care, according to the OECD, or about 41 per cent more than Canada's figure of $ 1,370 (U.S.).

How do they do it?

For starters, some health care economists say, Canada saves a bundle on administrative costs because, unlike America, it doesn't have payment systems run by hundreds of insurance companies as well as by federal and state government programs, each with its own rules.

"There's a feeling that because of multiple payers, there's a duplication in effort," said Roberta J. Labelle, an assistant professor of economics at the McMaster Health Sciences Center in Hamilton, Ontario. "With a single payer, there are economies of scale."

Any American who has ever labored over a health insurance form, trying to figure out which expenses would be covered, couldn't help but admire the ease of doing the Canadian paperwork -- it's about a simple as using a credit card. That ease also means sizable savings. Nearly 15 per cent of U.S. health expenditures goes for administrative costs, while in Canada, the figure is only 2-3 per cent, Labelle said.

Having the government run the insurance system also does away with the need for insurance company advertising and the charges that the companies tack on to reap a profit.

Canada also controls costs by keeping a tight grip on spending by hospitals and doctors. Hospitals in Ontario, which consume about 44 per cent of the province's health budget, receive a "global budget" to cover their costs. This budget, first established in 1969, is updated yearly to inflect general inflation -- not medical inflation, which is typically much higher.

To stay within limits, "we've had to reallocate resources internally," Stoughton of Toronto Hospital Corp. said. For example, he said, in Ontario, the average hospital has about two full-time staff members (or the equivalent in half-time staff) per patient on a given day. Few American hospitals operate with fewer than four full-time staff members per patient per day, he said.

The Ontario government also limits the availability of hospital beds: The number of acute-care beds per 1,000 people has dropped from 4.2 in 1976 to 3.4 at present, Labelle said, although many beds have been shifted to other uses, such as long-term care. As a result of the limits, and the increased use of bed for patients requiring chronic care, she said, Ontario's occupancy rates run about 94 per cent, compared with the U.S. average of 60 per cent.

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Access to big-ticket, high-tech medical equipment -- for example, magnetic resonance imaging that allows doctors to see detailed images of cross-sections of the body, and lithotripters, which use shock waves to crush kidney stones -- is also carefully controlled. Not only does government make sure that most sophisticated technology is confined to hospitals, it also exerts control, primarily through hospitals' operating budgets, over how many such machines there can be in the province and which hospitals can have them. In the United States, such decisions are made largely by individual hospitals seeking a competitive advantage in the marketplace and often lead to a proliferation of high-cost machines generating a lot of business -- much of which is arguably, unnecessary.

In Canada, hospitals have "no financial incentive to go out for all this stuff," Stoughton said. "I have a global budget. If I don't have [extra business]. I save money, and I look financially. Our doctors spend time on that technology at another institution, and we refer [patients] there. . . . It works."

As the sole purchasers of health care, Canada's provincial governments have much greater control over spending for physician services than U.S. insurance companies and the U.S. government have.

American doctors can charge whatever the traffic will bear, though they may run the risk of after-the-fact challenges from insurance companies. American doctors also face tougher restrictions under the federal medicaid program, which serves some of the poor, and the medicare program for the elderly and disabled. But, unless a doctor agrees to accept medicare's approved fee as payment in full, the doctor can and often does ask elderly patients to pay the portion of their charges that medicare won't pay.

The system is vastly different in Canada. In Ontario, which is representative of many provinces in this respect, the provincial medical association and the government negotiate the sum of money available for physicians' services. Once that's set, the medical association sets doctors' fees.

Under the terms of Canadian law (and, since 1986, Ontario law), doctors are prohibited from charging patients more than the government will pay -- a practice known as "extra billing." That restriction prompted an unsuccessful strike by Ontario physicians that resulted in continued hard feelings between doctors and the provincial government. In the meantime, provinces are also moving to limit the number of new physicians entering medical practice, on the theory that if there are more doctors, the will simply drum up more business for themselves. In British Columbia, an attempt to deny new physicians the billing numbers they needed to get government payment was struck down by the courts. But in Ontario, the government has already moved to limit the number of students graduating from medical schools as well as the number of residency positions for certain kinds of specialists in Toronto hospitals. Other provinces also are experimenting with controlling the supply of doctors. (See box, this page.)

QUEUING FOR CARE

Canada's system is not without its problems. Even though medical care costs Canadians a smaller share of the nation's GNP than Americans pay, the cost are eating up an increasingly large share of government spending.

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In Ontario, one of the wealthier provinces, health care has risen from 27 per cent of the provincial budge in fiscal 1978 to an estimated 33 per cent in the current fiscal year. The provinces' financial burden has also grown as the federal government, which has its own financial problems, has tightened the formula that set its contributions for health care.

Having government pay for health care makes it technically easier to control cost growth, but not necessarily politically feasible. Already, provincial governments' clampdowns on hospital spending have contributed to sporadic shortages of beds: Some patients must lie on stretchers in hospital hallways or do without some minor, but noticeable, amenities -- Maclean's said some maternity patients had to bring their own pillows, for example.

The clampdowns also have resulted in waiting (or queuing, as Canadians say) for certain kinds of nonemergency care. In Ontario, the most-publicized bottlenecks have been in cardiac surgery, where waits of several months are not uncommon. Cardiac surgery, of course, varies in type from the life-saving to the nominally life-enhancing, and in theory, the highest priority is given to those in greatest need.

But the queue doesn't always function perfectly. That, for instance, was the message trumpeted by newspaper headlines when Coleman died last December. Whether the postponements caused his death, which occurred a week after surgery, is a hotly debated matter. But there's no question that the case stirred public passions.

In the aftermath of that case, Ontario increased the province's cardiac surgery capacity and set up a special committee to investigate better ways to coordinate the way all doctors select high-priority candidates for surgery. "We clearly did fall behind on cardiovascular surgery, and we're now quickly moving to bring that back up to standard," Barkin said. "But that was no a deliberate withholding of funding because we wanted to have a queue there, it's because we couldn't respond fast enough to certain changes in practice patterns." There's nothing wrong with queues for nonemergency care, Barkin said, so long as they don't get too long.

Provincial governments also have learned that as in the U.S. medicare program, even when doctors' fees are limited, over-all costs can skyrocket if there are no controls on the number of services that doctors perform.

After extra billing was banned, for example, "doctors' cost [in Ontario] leaped by a quarter of a billion dollars in a year and half," said Scott, who was the province's deputy health minister under the Conservative government before the Liberals came to power in 1985. "My own personal theory is that doctors felt they had to be more entrepreneurial to make money," said Scott, a Toronto attorney who is chairman of a government-OMA task force on medical services. Doctors also began billing patients privately for services that had been free but weren't specifically covered by national insurance, he said.

As the volume of services has continued to push up Canada's total cost for medical service, provincial governments have taken a tougher stance with doctors. Ontario has begun insisting that unexplained increases in the volume of services offered count against doctors in future fee negotiations.

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The new course has been bumpy, at best. Last year, the negotiating process broke down in disputes over that concept, and the government unilaterally set the increase. Now, the two sides are trying to hammer out a new process for deciding future fees.

In the meantime, anecdotes circulate about some wealthy Canadians who don't want to wait for treatment heading over the border to hospitals in Buffalo, N.Y., or to the Cleveland Clinic in Ohio. There are also tales of physicians who have packed it in and moved south.

But there's general agreement that these instances are relatively few. In Toronto, people remember the brilliant children's plastic surgeon who moved to Texas in the wake of the failed strike. "He could turn the most horrible-looking monster creations into quite pleasant looking children," Scott said. "But he would turn you away at the door if you didn't have his fee over and above what [government] would pay."

"He was a real superstar," Stoughton said. "The U.S. system is an enormously rich system, and real superstars can be well accommodates. We don't lose a lot."

Furthermore, Canadians confess that they're terrified of falling ill or having an accident while visiting the United States, for fear they'll be refused care or be bankrupted by expenses that exceed what their insurance will pay. They talk about loading up on private health insurance for travelers before a trip south, showing the same anxiety that Americans might have about getting sick in Mexico.

CHANGING THE EMPHASIS

The budget crunch and the development of pressure points in the system have given some ammunition to the Canadian system's critics. Conservatives and some physicians in both the United States and Canada see the problems as the inevitable outcome of a welfare-state mentality.

"When I went into practice, people were grateful [for doctors' services] to the point that they would bring me goods as a sign of gratitude," said the OMA's Boadway, a former family practitioner. "Over the past 20 years," he said, "there's been a cultural shift . . ., and people began to say, "I'm entitled to, I demand to, and I will go' [to get medical care]. So people make more demands, and they do come to the doctor's office more."

Left-wing critics reverse the formulation. "What's wrong with the Canadian system is not the lineups and the Canadian system is not the lineups and the queues, or that this is what happens when government runs things," said Michael Rachlis, a Toronto physician and co-author of a controversial book, Second Opinion (Collins Publishers, 1989). "The problem is physicians' clinical decision making . . ., which really gums up rational allocation of resources in the social policy area."

Many of the arguments in Rachlis's book are echoed in less-combative terms by officialdom. "The primary determinants of health are social policy, wealth and personal choice," Barkin said. People mistakenly attribute too much benefit, he said, to medical and hospital care, "to aorta coronary bypass, artificial hearts and all that kind of stuff that is glamorous and high-tech but doesn't buy you

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a lot of population health. . . . In fact, poverty may account for more ill health, and the correction of poverty may account for more good health, than all of the expenditure on our total health care system."

After several blue-ribbon government panels came to some of the same conclusions about the need for the same conclusions about the need for a major shift in emphasis, Ontario Premier David Peterson set up the Premier's Council on Health Strategy, made up on 7 cabinet ministers and 24 outside representatives, to translate those goals into concrete actions. "We believe there is sufficient money in the system now to have effective, well-managed [care], but we need to put different incentives in place, around how hospitals are set up and funded, about how physicians are paid, around where people are cared for, and different ways of organizing care," said Marilyn H. Knox, executive director of the council.

In May, the council's first big report set out health goals for the province. It has the rhetorical gloss typical of government reports everywhere, bu the council says its lofty goals come with specific targets: making sure that 75 per cent of all health and social services are available in French in French-speaking communities, for example, and boosting the number of community health centers in Ontario by 50 per cent -- and doing both by 1995. And, Knox said, the provincial government has made health a top priority. It also issued a technical report with some controversial recommendations on how to restructure the incentives in the current hospital-payment and physician-payment systems, and it proposed more experimentation with alternative delivery systems, including some modeled on American health maintenance organizations.

The province has also launched a joint task force with the OMA, headed by Scott, to tackle some of the thornier issues of medical-practice guidelines and the cost-effectiveness of expensive new drugs and technologies. Unlike many such groups, Scott said, this one decided against letting narrowly focused experts set the guidelines, and instead brought in a varied panel of experts. A striking result, Scott said, was that the group's recommendations on cholesterol screening were far more conservative than those produced by a U.S. National Institutes of Health "consensus conference." The American group advocated mass screening for cholesterol problems. The Ontario group found, Scott said, that "not only was mass screening not justified, [but] that if you compare the cost of mass screening per life saved, bypass surgery is cheaper." In fact, the study found, if the U.S. guidelines were followed in Ontario, they could add $ 1 billion to the province's $ 11 billion health budget.

"That's enormously instructive when one talks about health care costs, to think that something as minor as high cholesterol, which really is minor despite all the hype -- it's a joke relative to smoking, for example, and heart disease -- could cost as much as 1/11 of the entire health care bill," Scott said.

SUPPORTING THE SYSTEM

Whether the onslaught of initiatives will forestall a financial crisis or severe service cutbacks in the Canadian system remains to be seen.

Ironically, although they disagree on the roots of the system's problems and on solutions, both the critics on the Left, such as Rachlis, and mainstream physicians at the OMA worry that reforms could run afoul of public expectations. "Let's assume you had the best preventive system in the world," Boadway said.

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"People still get breast cancer and appendicitis. The threat is, we can't look after the people who still get ill . . . that we will be expected to do a job with the level of care and excellence people have come to expect and have a right to expect, and we won't be able to do it."

Rachlis blames the problem on public misinformation. "The public doesn't believe what the experts claim they know," he said. "While the experts say that at the margins, the next dollar put into physicians' services has much less influence on health than money put into other areas, the public believes that unless we're putting every last penny of their tax dollars into hospitals, that we'll all by dying like drought-stricken Ethiopians.

But even though the public's reaction to reform may be the big unknown in the future of the system, the public's support for universal, tax-financed health care is in no doubt.

"As Canadians, we've chosen to have a universal system, and any time there's talk about making changes to it, we will see the consumer groups rising up and being quite clear about what they think about it," Knox said. "It's something that's really quite sacred here."

The notion that consumers might be more sensitized to the cost of health care if they had to pay a share themselves has no political constituency. Indeed, the Ontario government has moved twice in recent years to further protect the public from out-of-picket expenditures: in 1986, when it outlawed extra billing by doctors, and this year, when is abolished premiums for the universal outpatient care program in favor of a payroll tax on the province's employers.

Knox, like most of those interviewed, argued that requiring payments would create unacceptable barriers to care and undermine the concept of universality. "Yes, people appreciate costs when they pay them themselves, but when they don't get service, they also rise up and understand," she said. "It's a difficult one, but one point we're at here is that universality is not in question. The medicare system will be here, and we're not wanting to get into a two-tiered system where those who pay can get a different level of access from those who cannot."

GRAPHIC: Picture 1, no caption; Picture 2, All Canadians are entitled to health care, but the system's in flux. Julie Kosterlitz; Picture 3, Ontario's Graham W. S. Scott, Americans are looking north again. Brigitte Cavanagh; Picture 4, Cardiologist Ruth L. Collins-Nakai, Julie Kosterlitz; Picture 5, Toronto physician and author Michael Rachlis, Julie Kosterlitz; Picture 6, Ontario Medical Association's Ted Boadway, a former family practitioner, Since Canada adopted its program, people are demanding more medical care. Brigitte Cavanagh

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HEADLINE: But Not for Us?

SERIES: This is the second of two articles on Canada's universal health insurance system and whether elements of that system might be adopted by the United States. For the first article, see NJ, 7/15/89, p. 1792.

BYLINE: BY JULIE KOSTERLITZ

HIGHLIGHT:
Although Canada's health care system appears to offer some better alternatives to the pitfalls of the U.S. system, most U.S. experts say such a system wouldn't work here.

BODY:
Tell President Bush he needn't bother creating a kinder, gentler America, because it already exists: It's called Canada.

So goes the joke told these days among our neighbors to the north.

But as Americans study Canada's universal, tax-financed health insurance with an eye to reforming the U.S. system, health care experts on both sides of the border say the truth behind the quip makes wholesale adoption of a Canadian-style system here highly unlikely, at least anytime soon.

Social reformers in the United States, where at least 31 million people lack health insurance, envy the universality of the Canadian system. Washington policy makers and some large private employers have taken note of the comparatively low cost of the Canadian system: About 8.6 per cent of Canada's gross national product (GNP) is spent on health care, compared with 11.2 per cent here.

But for all the Canadian system's appeal, there are a host of subtle but profound societal and political differences between the two nations.

"It is a different country," said William L. Roper, the White House deputy assistant for domestic policy and a former head of the Health Care Financing Administration, which runs the medicare and medicaid systems. Roper, who visited Canada in January, said, "We have a common language, but there are important differences in values and cultural systems, and we must recognize that."

Aside from obvious differences, such as Canada's smaller population, its provincial system and its parliamentary government, there is a deeper difference: The U.S. emphasis on individualism and mistrust of government contrasts sharply with the Canadians' stress on the collective good and on government as its agent.

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Canadians insist that the key to their success comes from having a single, universal health care system, controlled by the provincial governments. Many American experts, however, argue that solutions to our problems must be found within the current framework: a quasi-free-enterprise system in which various government, corporate and individual purchasers of health care use a wide array of health care providers, from health maintenance organizations (HMOs) to solo practitioners to for-profit hospitals.

Some argue that the American approach is superior and that the creativity and innovation that set it apart should be preserved. Others call it merely a concession to political realities here. "You can make a powerful argument that we'd be better off with a Canadian-style system, but the intellectual logic . . . is almost disjointed from reality," said Lynn M. Etheredge, a private health care consultant with some health insurance clients. "You can't put it together politically; there are far too many economic interests with a stake in the growth of the U.S. health care system."

As for the solutions, however, there is little precision and scant consensus. A variety of policy makers have expressed interest in the notion of "managed competition," in which the government provides incentives for all purchasers of health care to contract with lean and efficient organizations, such as HMOs and their variants. But no one seems certain exactly how this might come about and how it would work.

Most concede that even an improved free-market system would probably not provide the same universality or control of costs that the Canadian system provides. Americans, they insist, aren't willing to accept the sacrifices this would entail.

FRAGMENTED SYSTEM

Few U.S. experts familiar with the Canadian system will deny that it has some attractive features. Beyond the universality of access and the cost control features are less obvious ones -- some defying American stereotypes about national health insurance.

Often thought of as centralized and rigid, national health insurance in Canada leaves most basic health policy decisions to provincial governments. "Their system is more federal than our," said Rep. Willis D. Gradison Jr. of Ohio, the senior Republican on the Ways and Means Subcommittee on Health. "There are substantial variations from province to province." At the same time, strong federal requirements of universal, comprehensive and portable coverage guard against the vast state disparities in coverage and eligibility in the U.S. medicaid program.

With most of Canada's health care financing and public health issues concentrated in relatively few hands at the provincial level, the provincial governments can, and increasingly do, take a more comprehensive approach to health care policy than the United States does.

In this country, payment decisions are not only divided between government, employers and individuals, but are also fragmented between different levels of government: Washington is responsible for medicare, the program for the old and disabled, and shares responsibility with the states for medicaid, which primarily covers the poor. Beyond that, cities and counties typically finance

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a variety of public hospitals and clinics for those who fall through the cracks.

Even at the federal level, the approach is fragmented. In Congress, different aspects of health care fall to different committees, which jealously guard their turf and tend to act independently. Within the bureaucracy, the Public Health Service is responsible for both advanced scientific research and more basic disease prevention and health promotion, and the Health Care Financing Administration not only administers medicare and medicaid but tracks broader health economics issues. The two operate like giant ships passing in the night.

The Canadian system's comparatively simple administration also belies part of the popular image of national health insurance as more bureaucratic and intrusive than a free-market system. American physicians and hospitals, for example, complain about the growing gantlet of insurance, HMO and government rules that they must negotiate.

"The positive thing in the Canadian system is that you don't have to distinguish patients according to payer class," said Robert A. Berenson, a Washington internist who was an assistant director of the Domestic Policy Staff in the Carter Administration. In the United States, he noted, "every payer is looking after their own interests, so it makes sense from their own standpoint. But, taken in the aggregate, it's crazy-quilt mess."

With multiple payers, "its's a real problem to practice medicine," he said. "You're continually caught in the middle. My malpractice insurance company makes me go to seminars or they'll cancel my insurance. The seminars tell me to suspend my clinical judgment and order tests so they'll know I have all the documentation. Simultaneously, the HMO's penalize me for ordering these same tests. Insurance has exclusions for preventive and routine care, which makes no sense from a medical standpoint, . . . and patients expect me to lie on their behalf' so that they can get such care paid for by insurance, a demand that "sets up weird ethical problems."

Just as bad, he said, is the lack of portability of employer health plans. "Time after time, it has happened that because a patient's job has changed, I might not be their doctor anymore. People moving across the system is not good medicine and has to have significant transaction costs," he said.

Canadian physicians agree. "We probably have more freedom" than American physicians do, said Ruth L. Collins-Nakai, an Edmonton (Alberta) pediatric cardioilogist, "because in the States, you have all those third-party [insurance plans] breathing down their backs."

Hospitals face some similar problems. The American Hospital Association, for example, has said that the typical hospital in the United States must already contend with 45 regulatory institutions. And though many hospitals are making out quite well in the brave new world of entrepreneurial health care, others are struggling. Many inner-city hospitals, for example, are overloaded with medicaid and uninsured patients other hospitals won't take -- often the sickest of the sick.

Canadian doctors and hospitals say they appreciate not having the problems their American counterparts face in contending with the uninsured and poor who cannot pay their bills. "I worked in [Boston] and had great difficulty

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turning away sick kids" who lacked insurance, Collins-Nakai said. "I couldn't do it."

Having government administer the program would also take some of the heat off employers, which insure about 136 million workers and dependents who are increasingly alarmed by the rates of increase in the costs they face. Adding to workers' sense of urgency is their new awareness of the huge and long-hidden costs of health insurance promised to retirees in years past. Part of generous early retirement packages meant to help trim payrolls, these promised health plans for retirees under age 65 have become a major cost item. Just how major has been driven home by a recent Financial Accounting Standards Board decision that will require companies to list these costs on their balance sheets at the time they're promised -- not merely as they're paid.

Employers, slow to confront costs, have been scrambling to catch up. In the meantime, they complain that they are subsidizing the uninsured, the small businesses that hire them and even the tight-fisted government programs.

And, having already seen their early efforts at cost containment fall short, companies are beginning to recognize that future solutions will have to be tougher. "Our prior cost-containment fall short, companies are beginning to recognize that future solutions will have to be tougher. Our prior cost-containment efforts worked only for a short term," until providers found the loopholes in the system, said Joseph W. Duva, corporate director of employee benefits for Allied-Signal Inc., a New Jersey-based manufacturer of aerospace and automotive equipment that recently launched an aggressive new health care cost-control program. "If companies have gone through the process we have, they would recognize they have to change how they deliver care."

MAKING A DIFFERENCE

But if the Canadian system appears to offer some better alternatives to the various pitfalls of the American system, American experts almost uniformly argue that such a system wouldn't work here.

Canada is different, they say. It has just a fraction of our population and 10 provinces to our 50 states, which presumably makes a universal health care system easier to manage.

The Canadian form of government is also different. Parliamentary politics at both the federal and provincial levels makes for a greater unanimity of purpose in government than does the American system of separation of powers between the executive branch and the legislative branch -- which itself has a fractious bicameral structure. In the Canadian system, when one party has a majority of seats, "you can pass a law faster than anything I've ever seen," said W. Vickery Stoughton, and American who for the past eight years has been president and chief executive officer of Toronto General Hospital, which recently merged with Western Toronto Hospital.

The parliamentary system also insulates rank-and-file elected officials from special-interest pressures to a greater degree than the U.S. system does. Interest groups, "instead of lobbying individual members [of Parliament], are more likely to go to the cabinet ministers," said Steve Clarke, senior legal specialist in American-British law at the Library of Congress. Unless the government collapses, Canadian elections are held only once every five years,

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and campaigns, which last a few weeks at most, are financed publicly and are subject to expenditure limits, Clarke said.

That's no small point, say those who doubt that a Canadian-style system would work here: There are large, entrenched and well-financed interest -- hospitals, doctors, the insurance industry and a whole network of workers and suppliers -- that could be expected to resist a system in which government pays the piper and calls the tune.

These groups not only exert influence in Washington but also have economic roots that sink deep into the American economy. "We have a health sector that is very large and very economically oriented -- very entrepreneurial," said health consultant Etheredge, who noted that "16-17 per cent of the expansion of GNP comes from the growth of the health sector. Hospitals are the largest employers in most metropolitan areas. U.S. health care is the eighth-largest economy in the world, with $ 500 billion a year in revenues, [and] the health sector is lots larger than the whole Canadian economy."

There is also the multibillion-dollar health insurance industry to contend with -- even though the business has not been very profitable in recent yeasr. In Canada, no private insurance can compete with the government plan. Although the government works through nonprofit intermediaries to administer claims, as the U.S. medicare program does, there is nothing like the private insurance industry that exists here. Nor, Canadians say, is there anything like the kinds of administrative and advertising costs the economy incurs in dealing with diverse, mainly for-profit insurers.

"To make their system work, the Canadians had to outlaw private [health] insurance," Grandison said. "We're not going to do that in this country. . . . It's not even on the table."

Having instituted their system in the mid-1960s, American nalysts argue, the Canadians also didn't have to contend with the kind of heightened public expectations about medical care that exist in the United States today. "The diet [of health care consumption] of the Average American consumer is much different now than it was then," Carl J. Schramm, president of the Health Insurance Association of America, said.

In fact, it's an article of faith here that neither providers nor the public would accept the trade-offs implicit in a system of universal, tax-financed care, such as the waiting lists for elective surgery that have sprung up in various provinces.

Those who make that argument are unmoved by a recent study of public opinion polls by Robert J. Blendon, chairman of the health policy and management department at the Harvard University School of Public Health, showing that a greater percentage of American than Canadians are unhappy with their national health systems and that Americans by a large margin prefer the Candian system to their own. Those results, the White House's Roper argues, reflect responses to loaded question.

"Can you imagine people settling for waiting a month for surgery when they get so angry at waiting an hour to see the doctor?" asked Thomas R. Reardon, a Portland (Ore.) physician who has visited Canada several times as a member of the Physician Payment Review Commission, which advises Congress on medicare

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physician-payment issues. "Canadians have a less-demanding, more-European culture," he said. "They don't have to have everything yesterday."

Of course, these critics acknowledge, the 31 million or more Americans without health insurance and the financial means to buy it already face waits for care or forgo it altogether if they can't afford it. But that concern doesn't evidently rank as high on America's list of pet peeves. "We do ration health care in this country by[tying it to individuals' financial] resources," said Reardon, a member of the House of Delegates of the American Medical Association (AMA). "We're the only Western nation in the world that hasn't solved the problem of universal access. It's a me-oriented society -- 'I have mine, let them get theirs.' "Rationing care to the rich, the middle class and the poor alike won't fly here, he said. "If they can buy it, they do not want to be told what they can't have."

American analysts also say a Canadian-style system would men an end to some innovations the U.S. system makes possible -- benefits Canada has gotten for free. "They benefit from having us across the border, because we can do the $&D and they can use it," Roper said. In a Canadian-style system, he added, "there are some significant things we would forgo -- innovation as to health care delivery systems, such as HMOs, and to the extent that we constrain spending too tightly, we'd constrain technological innovations."

U.S. critics of the Canadian system also contend that it has its own set of problems and that these are about to get worse as Canada faces fiscal challenges. Bed shortages may grow more acute, and old hospitals and equipment may face obsolescence. A recent decision by the Ontario provincial to abolish patient premiums in favor of an employer payroll tax, they note, has some businesses hopping mad. "I think a lot of us have rose-colored glasses on as we look north," Schramm said. "We don't see a system that is facing the same pressures we are and the kinds of limitations that may obtain there."

"Canada can't continue to run the way they are," said Sen. Dave Durenberger, R-Minn., who visited Toronto in June. "The system is breaking down now."

Stoughton disagrees. Critics have long predicted the system's demise, he said, "and it hasn't gone to pot yet."

A MATTER OF TRUST

But perhaps the biggest reason a Canadian system wouldn't work here. U.S. analysts say, is American's abiding mistrust of their government. Although the government has been on the cutting edge of health care cost containment, critics argue that in a universal system, if push came to shove, it would succumb to public and special-interest pressures for more spending. "Government won't have the will to tackle the problems" of curbing costs, Schramm said.

Variations on the theme are echoed elsewhere. Although they concede that the Canadian system appears to offer doctors and hospitals less hassle and more stability, American doctors and hospitals don't trust their government to run the system. "I used to be a knee-jerk liberal who thought it was a great idea, but I've seen how government does the medicare program, and I see mindless bureaucracy," Carter White House aide Berenson said. "If you expand that three times over, I'd be very worried about it."

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Hospitals are likely to take a similar view, especially because many of them are still making out quite handsomely.

"Ten years ago, we really felt like hospitals were public utilities," Etheredge said. "That psychology has changed quite a bit, and most are now independent businesses," and despite the attendant hassle, "most of them would still prefer to be free to be entrepreneurial."

Hospitals and doctors are also uncomfortable with the idea of collective bargaining with the government. The Canadian system, in which provincial medical associations bargain with provincial governments, is anathema to organized medicine in the United States. And U.S. physicians don't necessarily want the medical associations representing them. "I wouldn't trust the national or state medical association with my proxy," Berenson said, noting that the AMA claims only 50 per cent of doctors as members.

Employers also share this mistrust of government. Despite their panic over burgeoning health care costs, employers have historically eschewed any government proposals to control physician and hospital costs. In 1983, for example, when Sen. Edward M. Kennedy, D-Mass., and Rep. Richard A. Gephardt, D-Mo., proposed a system that would limit the amount any health insurance program would have to pay hospitals, not one company stepped forward to endorse the plan, a congressional aide recalled. Nor have employers raced to endorse Kennedy's more recent bill (S 768) that would require all employers to offer health insurance, although the plan would arguably address the concerns of big companies that many smaller employers have been getting a free ride at their expense. (The Senate Labor and Human Resources Committee narrowly approved the bill on July 12.)

"If they were being at all rational, all payers [employers and the government] would be on one side and providers on the other," Etheredge said. "That's never happened in the political debate in the U.S. The business community, for its own ideological reasons, has been on the side of providers. Whatever the problem, they say, governmetn regulation can't be the solution. So [business keeps] fighting for the right of providers to continue to rip them off. At least they're paying the price of their principles."

A few companies, primarily automobile manufacturers such as Chrysler Corp. and Ford Motor Co., have begun broaching the idea of national health insurance, but so far, the calls have been limited. Furthermore, critics say, troubled automakers have a particular self-interest: They have a higher-than-average ratio of retirees to active workers and, having overpromised benefits to their retirees, now want to shift the costs to the public and other employers. "It's Chrysler's second bailout," Schramm said.

Most employers believe that they can solve their problems better on their own. "Everyone's capable of doing it in different ways, I submit," Allied-Signal's Duva said. "Even smaller companies can do a lot, although they may not be able to get the same financial terms we did. I think limiting how [companies] do this to any one way is incorrect. I think generally speaking, the private sector can do things more cost-effectively," although managing health care costs might be an exception, he said.

Canadians don't share Americans' deep mistrust of government or their go-it-alone mentality. "When I came up here," Stoughton said, "the thing that

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struck me was that there's a social conscience in this country that says, 'We value the collective good over the individual.' Canadians trust government, and it's part of the social fabric of this country. That kind of societal attitude must have made it easier to introduce a universal health care system, and it has become the most popular social program in this country, bar none."

LOOMING CRISIS

Behind the arguments, however, is a palpable ambivalence among Americans. The same people who argue that neither health care providers nor the public would accept the strictures of national health insurance go on to tell you that the current system doesn't work well and that something has to give. "We need to take one lesson from the Canadians," Roper said. "We need to get serious."

But there's scant agreement on how to tackle the twin problems of access and cost control. In the past six months alone, at least a half-dozen groups have unveiled alternative proposals for accomplishing this. In January. The New England Journal of Medicine actually featured two different plans: one, by Physicians for a National Health Program, a national organization of about 1,250 doctors based in Cambridge (Mass.) Hospital, called for a Canadian-style system of health care budgeting; the other, by Alain Enthoven and Richard Kronick of the Stanford University Graduate School of Business, would oblige employers to pay 80 per cent of health costs of all full-time workers and require government to act as "public sponsors" or brokers for the care of eery one else.

Many politicians, business executives and health care providers maintain that the two goals can be achieved incrementally by building on the present system. Most care could be privately financed and managed, but government's role would be expanded to provide incentives to business to expand coverage of workers and manage costs better. Government would also have to broaden subsidies for those who have no other access to health insurance.

Roper, Durenberger and Berenson are among those who still express hope in the cost-cutting incentives of competition and in alternative health plans, such as HMOs, which receive a flat fee per patient to manage all their health care needs. "If, in the U.S., doctors were willing to group up and take on the provision of care, and the payment system rewarded them for that, that's our control mechanism -- that's the way we can get the market to work in this country," Durenberger said.

Government would have to police the market, Berneson said, to make sure that the savings "were based on performance" and not achieved by skimming off the healthier patients.

Stoughton, however, is dubious. "I was educated in the University of Chicago MBA program, which is extraordinarily free-market-oriented, but I've always felt that trying to apply economic principles to social programs didn't quite fit, and it doesn't," he said. "Unfortunately," he added, in the health care arena, "competition does not work."

In the meantime, some of the changes already under way are not unlike the constraints that analysts have been saying Americans would never accept.

For example, the powerful vested interests in the health care system are losing some of their unrestricted power. Since 1983, the medicare program has

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imposed substantial regulation on hospitals land is now in the process of overhauling the way it pays doctors. In fact, the legislation to institute" expenditure targets" that would put the brakes on year-to-year increases in medicare spending on physicians is modeled loosely on the approach taken by some Canadian provinces.

Just as significant, Congress has established three agencies to advise it on hospital, physician and, most recently prescription drug payment policy that have come to serve as intermediaries between the care providers and the government. "What's interesting is the extent to which [these agencies] have become the American institutions for negotiating," Etheredge said. "They are, in fact, becoming very influential."

Some large private employers are also demanding and getting concessions from insurance companies and providers. Over time, as more large employers have turned to self-insurance for health benefits -- about 60 per cent are now self-insured -- the insurance industry has dropped much of its risk-taking function and become either a claims administrator or a sort of watchdog for hire to review employees' use of health care with an eye to trimming waste.

Perhaps even more telling, employers are putting restrictions on employees' unfettered use of insured health care. The constraints are perhaps not as draconian as the several months' wait for elective surgery that patients face in Canada, but they are often unpopular in their own right. At Allied-Signal, where the new cost control plan includes financial incentives for employees to use approved physicians, Duva acknowledged that there were "some initial rough edges from an employee acceptance standpoint."

It is not clear that even these efforts will have the desired result -- for the companies or for the economy. Duva, though optimistic about the results of the new cost containment plan for Allied-Signal's 44,000 enrolled workers, notes that it doesn't include most of the company's 21,000 unionized employees or any of its 50,000 covered retirees, who are the heaviest users of health care.

Even if many large companies succeed in trimming their costs, some skeptics believe that in a system with multiple payers, the costs will turn up somewhere else -- in the parts of the system that are unregulated, or in the bills of those payers that don't have much market clout.

"You can't go at this piecemeal, and that's what's going on," Stroughton said. "The federal government's approach is, Let's do a little on managed care, and let's have some competition in the system. But, . . . if you don't fence the system in, the smart providers out there are going to take advantage of all the leaks."

Employers and the government admit they're worried. "Personally, as I see it, this is the last hope of corporate America if we want to keep [health care coverage] in a private setting," Duva said of the latest generation of employer cost containment efforts. "We have three-five years' time."

Gradison said he is "pessimistic in one sense. History suggests we're criss-oriented, and I don't think there's public awareness that there's a health care crisis right around the corner." An immediate sign, he said, are the hospitals threatening to shut down money-losing trauma units, which, along with emergency rooms, tend to have a high percentage of uninsured and

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low-income patients.

"Some people say, 'Let's give hospitals money for their trauma units,' but that misses the larger point," Gradison said. "I hope it doesn't take a crisis to force action, but it might."

GRAPHIC: Picture 1, Private health care consultant Lynn M. Etheredge, John Eisele; Picture 2, no caption; Picture 3, Joseph W. Duva of Allied-Signal Inc., Richard A. Bloom; Picture 4, Toronto hospital chief W. Vickery Stoughton, Brigitte Cavanaugh; Picture 5, Health Insurance Association's Carl J. Schramm, Americans expect much from medical care. Richard A. Bloom; Picture 6, Sen. Dave Durenberger, R-Minn, Richard A. Bloom

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July 15, 1989

SECTION: REPORTS; Health; Vol. 21, No. 28; Pg. 1795

LENGTH: 590 words

HEADLINE: Caring for Quebecois

DATELINE: QUEBEC

BODY:

The old walled city here is home to Canada's first hospital, Hotel Dieu de Quebec, an imposing stone structure built in 1689 and still in business. Three centuries later, Quebec Province, set apart from the rest of Canada by its proud emphasis on its French language and legacy -- and by its relative poverty -- is still known for its firsts in the health area.

It is, for example, the only province that sets limits on physicians' gross incomes. The current limit for general practitioners is about $ 164, 000 (Canadian). The province strictly limits the number of medical school admissions. It controls licenses for immigrant doctors, a policy that sparked a hunger strike recently by 20 immigrant doctors who were denied licenses. It also uses a carrot-and-stick approach to get doctors to practice where they're needed. Medical students who try to practice in doctor-packed Montreal get only 70 per cent of the standard fees.

Quebec also runs 154 local community service centers, where doctors work on salary, designed to improve access to care in poor communities for people who might otherwise show up in hospital emergency rooms for minor ailments or bounce from doctor to doctor. The centers offer a wide variety of services for the elderly, teenagers, the homeless and AIDS patients.

Quebec was also the first to launch a high-level commission to examine the future of health care. In April, the province unveiled a radical blueprint based on the commission's recommendations. Instead of separate boards of directors for each hospital, clinic and nursing home and community service center, the plan advocates regional boards to govern such institutions. Only members of the public -- no health professionals -- would serve on the boards.

Quebec's health care system evokes the same polar reactions in Canada that the Canadian system as a whole evokes in the United States. "Quebec has been in the forefront in doing innovative things in health care, " said Ruth L. Collins-Nakai, a pediatric cardiologist in Alberta. And, with per capita health care costs at $ 1,472 (Canadian), Quebec is well below the national average of $ 1,525. (A Canadian dollar is now worth about 84 U.S. cents.) But Quebec also has some severe problems, such as long waiting lists for hospital beds and for specialized care. Some physicians regard Quebec as the medical equivalent of purgatory. In 1986, Quebec's doctors in private practice earned about $ 84,000 (Canadian), after expenses but before taxes, compared with physicians' national average earnings of $ 97,000. Doctors who approach the quarterly income limit sometimes shut their offices for a few weeks.

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J. Edwin Coffey, an obstetrician and spokesman for the Quebec Medical Association (QMA), likens the system to socialism and says the government should control or subsidize health care only for the poor. "I could care less" about health care spending as a percentage of gross national product (GNP), he said. "The only question," he said, "should be, what amount am I willing as an individual to spend from my personal GNP?"

Others say the QMA represents a rear guard and note that the group has been bypassed by the government, which negotiates fees directly with two physicians' unions -- something the QMA is trying to challenge in court. "When the system first came in, it was an anathema to doctors, a cancer on society," said Saul Panofsky, director of the St. Louis du Parc community care center in Montreal. "Now, 95 per cent of them accept it."

GRAPHIC: Picture, Quebec's J. Edwin Coffey, What about personal GNP? Julie Kosterlitz

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April 30, 1991, Tuesday, Late Edition - Final

SECTION: Section A; Page 1; Column 1; National Desk

LENGTH: 3471 words

HEADLINE: Canada's National Health Plan Gives Care to All, With Limits

SERIES: The Price of Health: Third of Five Articles

BYLINE: By ELISABETH ROSENTHAL, Special to The New York Times

DATELINE: TORONTO

BODY:

Since a heart attack in 1989, Len Quesnelle has had a dozen tests to study the blocked arteries of his heart, spent weeks in intensive care because of chest pain and finally, in March, had a triple bypass.

He has seen his share of doctors and hospitals, but he has never received a bill, paid a health insurance premium or filled out a health insurance form. Although the price for his recent surgery, calculated in American dollars, was $14,000, he paid less than $200, for telephone calls and renting a television.

Comprehensive Health Insurance

As a citizen of Canada, Mr. Quesnelle is a beneficiary of one of the world's most comprehensive health insurance programs, the Canadian national health plan, which uses tax money to provide medical care to everyone at no charge.

But during his 18-month ordeal, Mr. Quesnelle often had to wait weeks for tests and treatment, and he almost had a second heart attack in the three-month wait before his surgery. Such delays, typical in Canada for certain costly procedures, would be considered imprudent, if not malpractice, in the United States.

At a time when some 33 million Americans lack insurance, the Canadian health care system serves as a taunting reminder that with a few compromises it is possible to provide quality care for everyone, and for less money. In Canada there are few machines to blast apart kidney stones, but no women go without prenatal care. There is no Mayo Clinic, but there are also no emergency rooms teeming with people who cannot afford a family doctor.

'Embarrassment to the U.S.'

"Canada is an embarrassment to the United States," said Vickery Stoughton, an American who is the president of Toronto Hospital.

But a majority of Americans, accustomed to receiving the most advanced medical care in an instant, without regard to price, may not be embarrassed enough to accept Canadian-style compromises.

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About the time Mr. Quesnelle had his surgery in Toronto, William Beagle had elective bypass surgery at Buffalo General Hospital, across Lake Ontario from Toronto. For a nine-day stay he received more than 50 bills totalling more than $50,000, each of which he submitted with a claim form to Metropolitan Life, which paid all but $18.

Since his case was complicated and would tie up his surgeon for an entire day, Mr. Beagle waited a long time for his operation by American standards: 10 days. The Toronto Hospital looks the same as any prestigious urban American center: computers in every room, transplant patients in intensive care units, even the same antiseptic smell hanging in the halls. But the health care structure behind the facade could hardly be more different.

Every Canadian, rich or poor, is promised equal access to doctors and hospitals through provincial insurance plans that cover nearly all medical expenses. With the flash of a red-and-white card, patients can obtain everything from nutritional counseling to lung transplants. Patients select their family doctors, and doctors for the most part order whatever tests they like, without the paperwork required by insurers that eats up a growing share of American medical costs.

Despite the governmental largess, Canada spends an average of 30 percent less per person on health care than the United States, for a stable total of 9 percent of the gross domestic product. The American level reached 12 percent of gross domestic product in 1989 and continues a relentless climb.

To make sure the country lives within its allotted means, the Canadian Federal and provincial governments control hospital operating budgets with an iron fist and doctor's fees through bargaining with provincial medical associations. To rein in costs, the government limits the number of specialists who are trained, limits purchases of expensive equipment and restricts costly procedures like open heart surgery to a few university hospitals.

New Things Come Slowly

To get the most for its money, the system is slow to offer expensive new machines and procedures, waiting until their medical value is solidly proved -- and, critics say, proved again.

And so the price of universal access is a degree of inconvenience and delay and, in fast-changing fields, sometimes settling for last year's treatment. Typical is the case of Albert Palmer, a 72-year-old farmer from Scarborough, Ontario. He waited from January to April for an operation to improve the blood supply to his feet, which had become agonizingly painful whenever he walked. Though there was no great danger, he had to endure the pain and supervise planting of his pea fields from a chair.

While the quality of care remains generally high, Canada's health system is showing signs of distress. Doctors predict that a barrage of expensive new technologies and an aging, sicker population will strain finances in the coming decade, leaving patients with longer waits, outdated technology, and even overt rationing.

"The only way you can afford universal health care is to run everything like a VW, which in the end gets you from place to place" said Dr. Alan

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Hudson, surgeon-in-chief at Toronto Hospital who will become its chief executive in July. "The problem is we try to run everything as almost a Cadillac. As medical costs rise, we can't afford it."

Satisfied Patients

Canadians Say System Is the Best

If patient satisfaction is the measure of good medicine, then the Canadian system is a resounding success. Ask a Canadian whether he uses the national system, and you get a perplexed pause. Of course he does: medical care outside the system is virtually outlawed. But more than that, Canadians are convinced the system is without rival.

"You don't want to wait when you're in pain, but there's no other choice," Mr. Palmer, the farmer, recently said. Far from threatening a malpractice suit, he added what is almost a Canadian refrain. "But I waited because this is the best medicine in the world."

Asked if he had ever considered going to the United States for treatment, Joseph Breglia, a 53-year-old Toronto lawyer who has been battling leukemia for five years, replied simply, "Not even a thought." Even wealthy Canadians who could afford to cross the border for treatment rarely do it.

Doctors who have worked in both countries say Canadians generally shrug off the system's inconveniences in a way that Americans would not.

"Canadians are used to peace, order and good governance -- we probably seem like a dull lot," said Dr. Donald Wigle, a Toronto cardiologist. "Americans go for life, liberty and the pursuit of happiness. I don't think they would put up with the waits."

Administrators at American hospitals agree. "If we can't provide bypass surgery in a timely fashion our patients will say goodbye and fly to Pittsburgh or Cleveland," said John Friedlander, president of Buffalo General.

Doctors Satisfied With the System

Like their patients, Canada's doctors are generally satisfied with the system, though there have been bruising battles with the government over fees. Doctor's charges for services are a good deal lower than what is charged in the United States, particularly in the surgical specialties, but because administrative costs and malpractice premiums are also much lower, most doctors earn salaries comparable to those of their American counterparts.

"I never have a problem recruiting internists," said Dr. Arnold Aberman, the chief doctor at Toronto Hospital. "That might not be true if I was recruiting cardiac surgeons since no one in Canada earns $3 million a year.

"Once you accept the limitations of the system, it's a pleasant place to be," he said.

Doctors send the government a list of patient visits each month and a few weeks later receive payment. Lawsuits are very rare, in part because Canadian lawyers must work for a fee rather than a share of malpractice settlements and

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patients cannot sue for punitive damages.

Statistics also speak well for Canadian medicine. On average, Canadians live longer than Americans, and Canada has a lower infant mortality rate.

'Never Having Your Hand Tied'

While Canada has little of the extreme poverty seen in American inner cities, its health statistics also reflect the good basic care enjoyed by everyone, including services like cholesterol checks and prenatal testing that are frequently not covered by insurance in the United States and that the poor often cannot afford.

"The overwhelming good thing about this system is never having your hand tied by the patient's financial status," said Dr. Lorne Becker, a family doctor who recently returned to practice in his native Toronto after 10 years of working in the United States. "It's a relief not having to fight with patients to get mammograms because they cost too much."

To promote access the Government maintains a ratio of general doctors to specialists of about four to one, as opposed to the one-to-one ratio in the United States.

But while basic care is good, it is rarely elaborate and the Canadians are generally less aggressive about monitoring and treating chronic conditions. For example, American doctors advise cholesterol testing for everyone over the age of 20 and treat patients with levels above 200. Canadian doctors test only those with other risks for heart disease and do not pursue further testing or treatment unless the level is over 265.

Canadian doctors say that medical studies support their low-key approach, but in their world of strictly budgeted resources, cost is always in the background.

Some Limitations

Delays and Travel, Travel and Delays

If Canada is generous with the basics, it is stingy with high technology.

Delays, travel and waits for cutting-edge treatments are intentionally built into the system, like speed bumps in a road, to make sure people proceed in health care deliberately and to prevent runaway use.

Except in cases of dire emergency, Canadians wait for weeks to months for a wide variety of expensive procedures, including advanced radiology scans, heart bypass and brain tumor operations and the destruction of painful kidney stones with a sound wave machine called a lithotripter. The supply of specialists and equipment for such procedures perpetually lags just behind demand.

"Everything is accessible to everyone, but not always accessible enough," said Dr. Irving H. Lipton, a cardiac surgeon in Toronto, a pile of X-rays on his desk from patients awaiting surgery.

He now has 54 patients in line for a cardiac bypass, 14 of whom he considers urgent. Such patients are frequently having chest pains at rest and often must

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wait in the hospital until surgery. Ideally, he says, he would like to accommodate the urgent patients in one to two days, but realistically the wait will be one or two weeks. Patients for whom the surgery is elective wait three or four months.

Calls Pleading for Patients

Canadian surgeons also lament the scarcity of advanced diagnostic equipment, particularly magnetic resonance imaging devices, the $2 million M.R.I. scanners that have transformed the treatment of brain, spine and joint disorders in this country. There are 15 M.R.I. scanners in all of Canada, and 2,000 in the United States. The United States has more than 10 times more per person.

Dr. Walter Kucharczyk, a radiologist who runs the M.R.I. scanner at Toronto Hospital, fields telephone calls every day pleading the cases of patients and loved ones, a task that he says "stinks."

A person with a quickly progressive paralysis qualifies as an emergency and promptly obtains a spinal scan to determine the source of the problem. But patients awaiting operations for brain tumors or confined to bed by ruptured disks are considered to be merely urgent and wait one to six weeks.

"These people are watched very carefully, but imagine being 30 years old and sitting around with a brain tumor growing, even slowly, in your head," said Dr. Ben Freedman, an ethicist at the Jewish General Hospital in Montreal.

Little Time for Elective Cases

Dr. Kucharczyk rarely finds room for elective cases, like patients with severe headaches or knee injuries, who would be scanned for good measure in the United States. "They wait a year and at that point, either the patient's better, had surgery or dead," he said.

Since high technology and specialty care are concentrated at a few centers scattered around the country, sick Canadians must be ready to wait and then travel, or travel and then wait. Kiki Margaritas, a 53-year-old patient from North Bay, Ontario, who has breast cancer, is spending April at the Princess Margaret Hospital in Toronto, 200 miles from home, so she can receive radiation treatments. The government pays her bus fare and the cost of a room at a residence for patients next to the hospital, but her family cannot afford to visit.

Not surprisingly, the long lines sometimes lead to charges of favoritism. Dr. Wigle said those with "influence and affluence" frequently jump to the top of waiting lists.

"There's a black market for medicine," Dr. Kucharczyk said. "People who have influence in the ministry or friends at the hospital get different treatment."

The Effect of Lists

Delays Bring Little Harm

In the vast majority of cases, the delays and inconveniences probably do no long-term harm, Canadian doctors agree. Mrs. Margaritas waited two months

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between her mastectomy and the start of chemotherapy. Such a gap would be unheard of across the border, though, and could theoretically make the difference between a relapse and a cure, said Dr. Kyu Shin, a cancer specialist at Roswell Park Cancer Institute in Buffalo.

In theory, people who run into trouble go to the front of the line, but "absolutely, people die on the waiting lists," said Dr. Lipton, the Toronto heart surgeon. Dr. Wigle, the cardiologist, has a patient who had a major heart attack while waiting for bypass surgery. Although he survived, his heart muscle was so damaged that he is now on another waiting list, this one for a heart transplant.

Driven by the the need to make money, American hospitals survive by doing more operations and ever more tests; driven by the need to conserve their fixed finances, Canadian hospitals stay afloat by doing less.

As one of the few cardiac surgeons serving the extended Toronto region with a population of six million, Dr. Lipton would like to perform more operations at the end of the day to erase the backlog, but cannot because the hospital cannot pay overtime to the operating room staff except in emergencies.

Things Done Quickly in U.S.

If Dr. Lipton needs to perform emergency surgery, he frequently has to take a less sick patient off the day's operating list. Contrast that with the United States: "Nights, weekends, we can always twist someone's arm and do another case," said Dr. Thomas Lajos, a surgeon at Buffalo General. Flexing his technological muscle, at 5 P.M. on a recent Friday he called to request an M.R.I. scan. It was done that night.

To many doctors, even more worrisome than the inconveniences is the fact that newer technologies and equipment are sometimes simply unavailable.

Dr. Hans Messner, a cancer specialist and chief of the bone marrow tranplant program at Princess Margaret Hospital in Toronto, says he would like to be able to use growth factors in his leukemia patients undergoing marrow transplants. These genetically engineered compounds have been shown to reduce the length of hospital stays and improve survival for the risky procedure. In the United States, they have crossed the boundary from experimental and have become state of the art.

"The government is reviewing the data, but there is significant inertia since these things are very costly," he said.

In the operating room, surgeons say that they are frequently using older equipment than their American collegues and, in intensive care, new gadgets come once a decade rather than every other year. Although Toronto Hospital has the biggest lung tranplant program in the world, it has not yet been able to buy a fiberoptic bronchoscope, a device inserted through the mouth to transmit perfect pictures of the lungs. Even many community hospitals in the United States have one.

Considering Cost

Doctors Calculate The Risks Closely

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Canadian doctors have learned to consider cost in their medical decisions, something that many experts say will have to happen in the United States.

Dr. Messner, the cancer specialist, knows his budget will allow him to do only about 55 bone marrow transplants in the coming year. At $100,000 each, he says he will devote this resource to the patients most likely to survive.

"You learn to be frugal," he said. "If I filled my beds with patients who had only a 10 percent chance of survival, at the end of the year I'd have only 5 left. So instead I fill them with patients who have a 60 percent chance and end up with 35."

When waits become too long, doctors and patients often decide to make do with more primitive and accessible technologies. For back surgery, when an M.R.I. scan is unavailable this means a test called a myelogram, which involves injecting dye into the spine. It is uncomfortable, complicated by allergic reactions and requires a hospital stay.

Desperation Drives Patients South

And when desperate, Canadians have a final option: to go to the United States, whose hospitals have served as a convenient pressure valve. The Canadian system generally pays American hospitals for care it cannot reasonably provide, although patients must get prior approval.

In a typical case, last year when James McGillis of Burlington, Ontario, developed excruciating pain from a kidney-stone blocking his bladder, he was sent to a private center in Buffalo to have the stones pulverized because the single lithotripter in Ontario was solidly booked. When the delays become unacceptably long even by Canadian standards, Ontario has paid for coronary bypass operations in Detroit and M.R.I. scans in Buffalo to give the health ministry time to juggle its resources.

Although Canadian doctors often wish for a new high-speed bone drill or a second scanner, some experts say that technical plenty in the United States does not always lead to better care, just to more care, while basic needs go wanting.

"Its nice to have a lithotripter in Outer Snowshoe, but that money comes from somewhere else," said Dr. Adam Linton, a kidney specialist in London, Ontario. The travel required by centralization of certain procedures makes treatment inconvenient, but also more assured in quality, he added.

And treatments are unavailable to many citizens of the United States for other reasons. Studies have repeatedly shown that black Americans benefit from high technology like heart bypass and cancer treatment far less often than whites, for example. Uninsured patients, or those on Medicaid, often can wait months for an elective M.R.I. scan or even a general check-up.

Pressure on System

Canada's Costs Are Soaring Too

Despite the Government's efforts to control costs, in Canada as in the United States the press of soaring medical prices and ever-better, more costly technology threatens to tear the system apart.

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Although Canadians demand the best in health care, they are reluctant to pay more taxes for it. Already the southbound Peace Bridge from Ontario to Buffalo is crowded with shoppers driving to avoid sales taxes totalling 15 per cent, which have been driven up in part by health expenses.

Hospitals striving to offer advanced treatments on limited budgets have been increasingly forced to make unhappy compromises. "When a hospital is given a budget and starts to run out of money it has no choice but to cut services," Dr. Linton said.

Hospitals Sometimes Close Beds

For many hospitals, the simplest solution is to close down beds, a drastic measure in a system already running at capacity. Other hospitals have limited the number of joints an orthopedist may replace or the number of patients who may be on dialysis.

So far, that has resulted mostly in delays being a little longer or travel distance greater.

"We have not yet had to kill anyone by not providing dialysis or a transplant, but the issue is at a flash point." Dr. Linton said. "We are running out of maneuvering room financially."

Indeed, as costly new machines and drugs are proved to treat a wide range of maladies, doctors wonder how the system will afford them. Some provinces are considering charging fees to patients, and other provinces are experimenting with health maintainence organizations like those being promoted in the United States.

"People look at Canada and think we have a panacea," Dr. Wigle said. "We do not. We both have to learn from each other."

GRAPHIC: Photos: Struggling against leukemia for five years, Joseph Breglia said he had never considered going to the United States for treatment. Janet Young attended to Mr. Breglia's blood treatment in an outpatient clinic at Princess Margaret Hospital in Toronto.; Although the Canadian Government pays her bus fare and cost of a room next to the hospital, Kiki Margaritas must travel 200 miles to receive radiation treatments. (Photographs by Mike Groll for The New York Times) (pg. A16)

Graphs: Health spending as a percentage of gross deomestic product in the U.S. and Canada from '60 to '89 (Source: George J. Schieber and Jean-Pierre Poullier, 'Health Affairs') (pg. A1); 'Gauging Health Spending' shows spending per person in U.S. and Canada from '60 to '89 (Source: George J. Schieber and Jean-Pierre Poullier, 'Health Affairs) (pg. A16)

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THE FEDERAL PAGE

Health Industry Lobbyists Boost President's Plan

By Gary Lee
Washington Post Staff Writer

While many inside and beyond the Beltway may be confused about what President Bush's new health care plan means for them, Washington health care lobbyists know where they stand.

Corporate and insurance industry lobbyists, such as Pamela Bailey, a spokeswoman for Healthcare Equity Action League (HEAL), favor the very kinds of moderate reforms Bush espoused in the administration plan released yesterday. "It's a very strong plan," said Bailey, whose lobbying coalition represents 340 insurance companies and businesses. "It provides the basis for us to solve this country's health care problems."

Consumer groups such as Public Citizen or Citizen Action, on the other hand, say Bush's plan is an inadequate response to the soaring [illegible] and other problems of the nation's health care system. "It will neither control prices nor provide greater access," said David Himmelstein, a Harvard professor and leading advocate of nationalized medicine.

Bailey, and other corporate lobbyists, have reason to be enthusiastic. The details of the Bush plan include most of the proposals that insurance industry and corporate leaders pitched in meetings with White House and congressional leaders in recent weeks: proposals to give uninsured Americans tax credits and reduce doctors' malpractice premiums. The Bush and corporate health care blueprints also flatly reject a national health care system structured after the Canadian system, or a "pay or play" plan under which businesses would either pay for health care for their workers or pay a special tax for government-sponsored health care.

Flush with apparent success in helping mold Bush's plan, corporate lobbyists now are undertaking an all-out bid to get it—or a close facsimile—enacted. HEAL, whose membership includes the influential U.S. Chamber of Commerce, the National Federation of Independent [illegible]nesses and the Health Insurance Association of America (HIAA), has already launched a lobbying battle against a national health care system and for a more moderate adaptation of the current system.

With their support among GOP lawmakers assured, the corporate lobbyists are developing a strategy to shore up Democratic support. To do so, they have expanded their staffs and cornered some of the best-known Democratic public relations executives in Washington. AETNA Insurance for example, has hired Jody Powell, a former adviser to President Jimmy Carter and now a partner in the public relations firm of Powell and Tate. HIAA commissioned Carter Eskew, a communications firm often used by Democratic candidates, to help devise a public relations strategy.

The situation isn't quite the same for those who favor a Canadian-style health plan. When Bush outlined his plan in Cleveland, Citizen Action, for example, sent several dozen people to demonstrate against it.

Though their tactics may be different, both sides are seeking the ear of Sen. Lloyd Bentsen (D-Tex.), who as chairman of the Senate Finance Committee will play a leadership role on pending health care legislation, and presidential hopeful Sen. Tom Harkin (D-Iowa), who has yet to outline a specific health care plan.

They are also attempting to sell their plans to a public beyond Congress.

Last October, Common Cause released a study showing that medical and insurance industry political action committees gave over $40 million to members of Congress.

To help polish its public image and get its message across to a broader audience, HEAL has hired Burson Marsteller, one of world's leading public relations firms. With Burson's help, HEAL recently held a conference for journalists at the National Press Club and ran a full page ad in USA Today costing approximately $60,000. "Everyone knows that we need health care reform," it said. But "we cannot afford to scrap the current system for a costly new federal bureaucracy."

A HEALTHY HISTORY OF DEBATE

At the start of the century, a diverse group of advocates including the American Medical Association, the Socialist Party and President Theodore Roosevelt, began calling for government-paid health insurance for all Americans. A long, often fierce series of battles ensued, swinging between populist calls for a strong government role in health care and calls for a private, free market approach.

Here are some milestones in the debate:

1910-1919: Bills were introduced in several state legislatures to cover workers and dependents in state-administered plans financed by employers, employees and taxes. The idea was originally backed by the American Medical Association, then doctors and medical societies around the country forced the AMA to reverse its stand, and the idea died.

1933: The American Hospital Association endorsed a new plan, Blue Cross hospital insurance.The AMA attacked the plan as "half-baked," but private health insurance, the kind most Americans now have, was born.

1935: President Franklin D. Roosevelt endorsed the principle of compulsory national health insurance but did not ask Congress to adopt it.

1943: A Democratic trio—New York Sen. Robert F. Wagner, Montana Sen. James E. Murray and Michigan Rep. John D. Dingell Sr.—introduced the first Wagner-Murray-Dingell national health insurance bill. It called for a payroll tax on employers and employees, and government-paid doctors. The bill was introduced in some form every session for 14 years without ever making it to the floor of either house, yet keeping the issue alive. (Dingell's son and successor, Democratic Rep. John D. Dingell Jr. (D-Mich.) introduces a similar bill each session.)

1945: FDR, elected to a fourth term, promised to deliver a strong health message to Congress, but died. President Harry S. Truman adopted the idea, and backed a plan similar to the Wagner-Murray-Dingell bill. A hot national debate ensued. The American Medical Association launched an expensive public relations campaign and labled the Truman plan "socialized medicine." The AMA then warmly embraced private, voluntary health insurance programs like Blue Cross. The Truman effort got lost amid the Korean War effort.

FIRST TO INTRODUCE A HEALTH CARE BILL

Sen. Robert F. Wagner (D-N.Y.)

Sen. James E. Murray (D-Mont.)

Rep. John D. Dingell Sr. (D-Mich.)

1950: Lacking support for a federal health plan, advocates of government health insurance began to think of covering the elderly as politically salable, and a foot in the door for later universal plans. Truman's Federal Security Agency head, Oscar Ewing, talked of making 60 days' hospital care a year part of Social Security.

1953: President Dwight D. Eisenhower killed all efforts at a government plan, unsuccessfully proposing measures that would strengthen private health insurance.

1958: Sen. Robert S. Kerr (D-Okla.) and Rep. Wilbur D. Mills (D-Ark.), chairman of the House Ways and Means Committee, sponsored the Kerr-Mills plan giving states modest matching federal funds to care for the aged poor. With backing from the AMA and Republicans, the measure passed.

1960: Sen. John F. Kennedy hit the presidential campaign trail promising care for the elderly financed with an increase in the Social Security payroll tax.

1964: President Lyndon B. Johnson and Rep. Mills reached a compromise. The aged would be taken care of by Medicare and a new federal-state Medicaid plan would cover more of the poor. Poorer states, like Mills's Arkansas, benefited from a disproportionate share of the federal dollars.

1965: Congress enacted both Medicare government coverage for the elderly and Medicaid, despite AMA opposition. They went into effect in 1966.

1974: With millions of Americans still uncovered, President Richard M. Nixon proposed a Comprehensive Health Insurance Program (CHIP) to mandate or order most employers to cover their workers. Under the system, patients would pay both a modest deductible before any coverage and 25 percent of all bills, limited to a maximum annual liability. Mills and a new player, Sen. Edward M. Kennedy (D-Mass.) endorsed a similar but more generous plan. Democratic and Republican support was weak or split for either plan. Mills lost credibility when he became involved with a dancer named Fanne Fox. Watergate distracted Nixon's and the nation's attention, and nothing happened.

1991-1992: With ever more millions uninsured, health care returns to the front burner. More than 30 bills are introduced in Congress. Most take one of four approaches: Tax credits and vouchers, with encouragement for managed care such as health maintenance organizations; pay or play, under which employers must either provide health insurance or pay into a government fund for the uninsured; stronger private health insurance; or universal, government-administered health care as practiced in Canada.

—Compiled by by Victor Cohn

Details of Health Care Plan Filter Out

Bush Would Rely on Tax Credits, Private Insurance Reform

By Spencer Rich
Washington Post Staff Writer

The basic shape of President Bush's still unreleased plan to solve the nation's health care crisis became clearer yesterday as details began filtering out from administration officials and other sources.

The plan rejects the two favorite Democratic solutions—national health insurance and a federal requirement that all employers provide health insurance to their workers—in favor of expanding coverage through tax credits and reform of the private insurance market.

The Bush plan is expected to include these key elements, phased in over five years at a federal cost of about $100 billion:

■ Federal "refundable tax credits" for low-income Americans, which Secretary of Health and Human Services Louis W. Sullivan said yesterday would work in practice as "payment vouchers." The credits would be worth up to $1,250 for a single person and $3,750 for a family below the poverty line; smaller amounts would be available to persons with incomes up to 50 percent above the poverty line. The uninsured could use the vouchers to obtain insurance from private companies, subject to certain conditions which would be monitored by state governments.

According to administration sources, the federal government would allow states to expand the number of low-income uninsured persons covered by existing Medicaid programs or newly created state programs. The uninsured could then obtain coverage either through the state programs or through use of the vouchers.

■ The vouchers would be paid for, in part, by imposing a per-capita ceiling on the annual growth of federal matching payments to the states for each Medicaid enrollee. The cap would allow a state's Medicaid matching funds to grow by the annual national inflation rate plus some additional amount, perhaps 2.5 percent.

According to the theory, this cap would not only hold federal spending growth down and provide money for the tax credits, but would also encourage the states to enroll their Medicaid patients in HMOs and other managed-care programs, which are thought to control costs better than traditional payment methods because the insurer carefully monitors waste and overutilizations.

■ To broaden access to health insurance for individuals and workers whose employers do not provide it, the administration would seek a wide variety of changes. The Bush plan would allow small firms to band together in purchasing pools to get insurance more cheaply and easily; guarantee that anyone who wants to buy insurance can purchase it, and cannot be excluded because of preexisting health conditions; and minimize risks to insurers through insurance pooling systems such as the "assigned risk" system now used for auto insurance.

■ To help middle-class taxpayers pay for insurance, the proposal would make it easier for individuals with incomes up to $60,000—and families up to $80,000—to take federal income tax deductions for health insurance premiums.

■ The malpractice insurance system, which some argue encourages waste by prompting doctors to practice "defensive medicine," would be altered to reduce lawsuits.

■ The use of HMOs and other forms of managed care would be encouraged to contain costs.

■ Studies of which medical treatments are the most effective would be completed.

Senate Majority Leader George J. Mitchell (D-Maine) said that on the basis of what is known, the Bush plan is "a non-solution . . . . It will do nothing to control costs, and does not appear in the brief summary available so far to provide insurance coverage for all Americans. The president has yet to tell us what it will cost and how he proposes to pay for it."

Sen. Edward M. Kennedy (D-Mass.) said the proposal "flunks the two basic tests of real reform—they refuse to guarantee coverage for all Americans and they pay only lip service to control health care costs."

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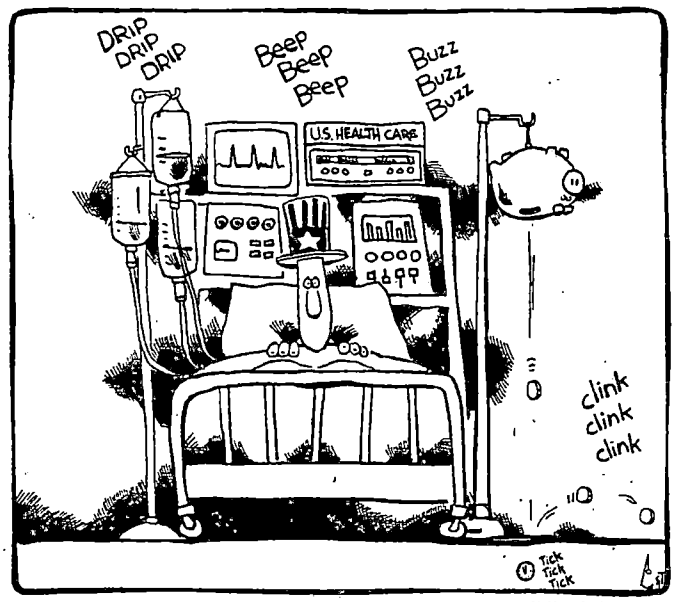

BY TOLES FOR THE BUFFALO NEWS

Jessica Mathews

Health Care: Drawing the Lines

The State of the Union address and Speaker Thomas Foley's response clearly drew the battle lines on health care. The Democrats want a system that will cover everyone, with the government as the provider of last—or, if necessary, first—resort. The president hopes merely to make the present system marginally less chaotic and perhaps (the details have not been made public) slightly more affordable for a very few.

The Democrats are right to insist that 35 million working Americans with no coverage shames us all. The Republicans are right to believe that government-managed health care could well mean lower quality care at higher cost, as it has in the Veterans Administration and the military.

Before a national debate on health has even begun, we have split, seemingly automatically, along a predictable partisan divide. That is a tragedy because it masks the real issue, which both parties have sidestepped. Until that issue is joined, all reforms will fail.

The crux of the matter is that modern medicine can deliver more health care than any society can afford. Unlike any other economic sphere, there are no inherent limits. We can squeeze out greed and waste, even cure the administrative nightmare that passes for our payment system, but as other countries that have already done all that know, it will not be enough. In order to control exploding medical costs, we will have to decide how much of what kinds of health care we can afford. Call it rationing, allocation, or making choices, it will be painful but is unavoidable.

Growth in medical costs of 12 to 13 percent per year means that costs double every six years and triple in less than a decade. Administrative reforms could produce substantial one-time savings, but they will not change the underlying trends. With health care now consuming 14 percent of GNP, up from 7 percent in 1970, we cannot afford to deny the real issue for much longer without lasting damage to the economy.

Without imposed limits, medical costs are driven skyward by biology, demography and technology. The human lifespan isn't precisely known, but it is finite. As mortality falls—whether through healthier living, preventive medicine, or treatment—people live longer. A person over 75 uses 10 times the medical care of a 40-year-old. In this sense, a good health care system, by creating an older population, is inevitably the victim of its own success. (Some believe that ultimately it may be possible to slow aging, compressing its infirmities into fewer years before death, but this remains a theoretical hope.)

The process is well advanced in the United States. Today, those over 100 are the fastest growing age group, those 85-100 the second-fastest. The effect will be magnified as the huge baby boom generation—now one-third of the population—reaches old age. The youngest of them will be 65 in less than 20 years.

Technological advance in medicine in the past few decades has been spectacular and shows no signs of slowing. More diseases can be screened for, diagnosed and treated, more body parts repaired or replaced, more genes identified and manipulated. For every new drug, instrument or procedure that can do the same job at lower cost, there are many that do the job better but at higher cost and several more that do a new job.

There is no end to this if we continue to believe that medical "need" is the sum total of what is possible. Ethicist Daniel Callahan points out that "we do not think of people 100 years of age as needing artificial hearts. But we should know that if an effective heart is eventually developed and someone will die without it, then there will be a need for it." As instruments continue to get smaller, optics better, the immune system deciphered and harnessed and the human genome fully mapped, the possibilities become, if not infinite, at least nearly so.

That leaves us with the absolute necessity of rationing care, of ruling out some progress as unaffordable and of separating needs from possibilities. We ration already without admitting it by spending without limit on anyone who makes it inside the system and leaving out vast numbers at the bottom.

Former Colorado governor Richard Lamm, a longtime student of health care, recently took a world trip to compare medical systems. He found America unique. "As people are turned away from admission rooms, massive resources in other parts of the hospital are spent on patients for whom there is no happy outcome. America has the best technical health care, yet the cruelest and least ethical health care delivery system in the developed world."

The choices we Americans must face have little to do with whether you are a Democrat inclined to use government to solve a crying public need or a Republican sure that will only make bad worse. The choices are linked to the two parties' relative concern for those in the middle and bottom of the economic scale, but they transcend even that difference. They have to do with deciding how to sensibly and humanely care for the terminally ill and how to rule out some very expensive and marginally, or even clearly, effective procedures. They have to do with how much health care we think we can afford. None of the answers fits in a campaign sound bite, but this is the time to begin posing the right questions.

The writer, vice president of World Resources Institute, writes this column independently for The Post.

President's Plan Elicits Many Questions, Gives Some Options

By Malcolm Gladwell and Spencer Rich
Washington Post Staff Writers

What is distinctive about the Bush administration's plan?

Unlike Democratic congressional proposals for a "play-or-pay" system or a single nationalized program, the Bush plan relies heavily on existing institutions and free-market economics, it includes a series of targeted structural reforms and a specific set of proposals to make health insurance more affordable for the working poor and middle class.

How do the financial assistance programs work?

For those with incomes near the poverty line, the plan would provide credit vouchers redeemable at health insurance companies. For single people making $5,600 or less, the voucher is worth $1,250. For couples under $10,000, it gives $2,500. For families under $14,300, it give $3,750.

These vouchers would be certificates that could be picked up at a state unemployment benefits office or some other state-designated agency. The higher the income, the less the voucher amount—up to 150 percent of the poverty line. Then the voucher system would stop and a tax-deduction credit system would start. Individuals making up to $50,000 could deduct up to $1,250 of the cost of health-insurance premiums on their federal income tax filings. Couples making up to $60,000 could deduct up to $2,500, and families making up to $80,000 could deduct $3,750.

Before taking the deduction, an individual would have to subtract from the total cost of insurance any amount paid by an employer.

For example, a family of four with an annual income of $50,000 pays $3,750 for insurance premiums, of which $1,000 is paid by an employer. The family could deduct the difference—$2,750.

Could the subsidies and vouchers actually solve the problem of the uninsured?

The Bush administration predicts that over five years the plan will reduce the numbers of uninsured from 34 million to 4.9 million. Others are less optimistic.

Karen Davis, a health economist at Johns Hopkins, points out that only 28 percent of uninsured Americans have incomes below the poverty line, and thus would qualify for the largest assistance benefits. And even for them, the subsidy would only be partial: The cost of a year's health insurance coverage for a family of four averages just over $5,000. That means a family making $10,000—which qualifies for the full $3,750 credit—would still have to find $1,250 in after-tax cash to pay for insurance.

The higher an insured person's income, the less effect the plan has. Consider a family of four making $20,000. In their 15 percent tax bracket, even the full $3,750 health tax credit would be worth about $563. They still have to come up with about $4,437 to pay for $5,000 worth of medical insurance.

"That's not going to be enough to help you afford insurance," said Davis.

That $5,000 premium rate, of course, is an average. In some rural areas, the credit might well be enough. But in the District, for example, the small group rate for a family in which the parents are 40 years old is $7,872 per year. For a 40-year-old single man, a year's coverage is $2,808.

"For poor families, a tax credit of $1,250 per individual is a cruel hoax," John J. Sweeney of the Service Employees International Union said.

"I would guess that this would cut the [total number of] uninsured in half," said Mark Pauly, a health economist at the Wharton School in Philadelphia. "The part that is questionable is: What is it going to do for the uninsured who aren't that poor? . . . I think you will need more than just tax breaks of that magnitude."

How would the plan affect those who already have insurance?

In two ways. First, many Americans lose medical coverage when they switch jobs. This is because many insurers refuse to cover "preexisting conditions"—illnesses they had in their previous jobs. The Bush proposal would prohibit this practice.

Second, the plan also would make it illegal for an employer to exclude from coverage employees who suffer from certain expensive illnesses, such as AIDS.

How would the Bush plan affect small businesses?

Substantially. The plan attempts to encourage small businesses that do not currently offer health insurance, or that are suffering from high premiums, to band together and form what are called "health insurance networks" (HINs). These networks, which would be administered by a union, a trade group or a board made up of the member companies, would then go to a health insurance company and negotiate for group coverage.

The chief incentive to the formation of HINs is to level the playing field between small and big companies. Currently large companies are able to insure themselves, paying health premiums to an in-house fund from which they pay for claims. This allows them to escape certain costly regulations, such as state laws requiring that they offer various expensive benefits, state laws limiting their ability to negotiate lower prices from hospitals as well as local taxes on insurance premiums.

The plan would give those same advantages to an HIN currently held by a self-insured company.

In addition, the plan assumes that HINs would flourish because workers could use their vouchers or their tax credits to help pay for insurance, making a network more affordable than it would be if the full cost had to be borne by employers. Also, insurers will be able to offer far cheaper insurance to the HINs than they would have been able to each of the member companies individually, because the costs of administering a large plan are much less than the costs of running many small plans separately.

How would the plan affect individuals who aren't in an HIN?

One simple proposal would allow a person to give a credit voucher to an employer, who could supplement it and buy coverage, or refer the worker to a place where a policy could be purchase.

Another way would be for the worker to give his voucher to Medicaid. Under the plan, states would have the option to expand Medicaid coverage to all those eligible for vouchers, which means that all persons up the poverty line with no health policies would be guaranteed Medicaid coverage.

Or, of course, the individual could use the voucher to obtain a policy.

How would the plan affect the way insurance companies do business?

Carl Schramm, president of the Health Insurance Association of America, a trade group for the health insurance industry, calls this part of the Bush proposal "radical."

Under the present system, insurers based their premiums for each company they insure on the amount of money that company spent on health care during the previous year. A small company with one or several employees who became very, very sick, for example, would face huge increases in its premium costs for the next year, and might not be able to afford insurance at all. By the same token, a company that employs mostly young and healthy people would have much lower than average health insurance premiums.

The Bush plan would gradually move away from that system toward what is called a "community rating," which is based on large pools of people who live in the same state. Insurers would be required to charge every insured person in a given "community" roughly the same premium price, spreading the costs of insurance evenly across young and old, healthy and sick.

Would the plan curb skyrocketing health care costs and how much would it save?

The only specific cost-saving device is a proposed curb on the growth of Medicaid spending, with the goal of holding annual budget increase to the rate of inflation plus perhaps 2 percent within a few years.

The administration estimates that a variety of stategies will change incentives in the health system and eventually save $394 billion over the next five years and $1 trillion by the end of the century.

The plan would accomplish this, the administration argues, by encouraging of growth of "managed care" systems in which doctors and hospitals have a direct financial stake in holding down the amount of money they spend on patients. The plan would also strongly pressure states to use managed care in administering Medicaid and to push for its use throughout the state's health system.

In addition, the plan lists a series of specific options to cut costs.

The administration also proposed: research on the effectiveness of various treatments; reduction of paperwork by using "smart" health insurance ID cards for computerized payments and more uniform billing and coding systems; increased preventive care; and various changes in malpractice laws designed to discourage doctors from practicing "defensive medicine" for fear of being sued.

Marilyn Moon, a heatlh economist with the Urban Institute, said she felt the savings estimates were "soft" and "optimistic."

In theory, several economists said, providing health insurance to those who are currently without it would eventually reduce the health insurance premiums of everyone else, because hospitals would no longer have to recoup the money they lose on the uninsured by charging higher prices to those with insurance.

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Health-Care Panel Lacks Consensus

By Spencer Rich
Washington Post Staff Writer

A Social Security advisory panel headed by Deborah Steelman, a former policy adviser to President Bush, is having a hard time deciding what to do—a reflection of the tremendous financial and ideological conflicts over revisions of the health system.

The panel began in 1989 with high hopes it could craft an overall solution to the problems of 34 million people without health insurance. But yesterday's meeting made clear that the committee—which includes Democrats, Republicans, health professionals, union officials and insurance executives—is deadlocked over any comprehensive plan for overhauling the nation's health care system.

Not a single member of the panel expressed any optimism that when votes are taken later this month, a significant majority of the panel would recommend any of 10 comprehensive sample plans its staff has drafted. Those plans range from a national health insurance plan beloved of many liberals to a "free-market" system in which all people get tax vouchers from the government and use them to buy their own plans.

Panel member Larry Atkins, a Social Security specialist who formerly worked for the late Sen. John Heinz (R-Pa.), said that among the panel's 13 members, there are "no more than four votes" for any one of the 10 plans.

But the panel does appear ready to recommend a series of substantial incremental changes in the current system that officials said could help 22 million people. These include:

- A health insurance system open to anyone under 22 in a given area and not covered by Medicaid or private insurance. The premiums would be related to income and local schools, which is where most of those eligible will be found, would be used as central locations to make the insurance available.
- School-based preventive-care, primary-care and dental health clinics for all children from infants through grade school, whether enrolled in the school or not. Low-income children would be subsidized. Costs would be paid in part by charging Medicaid or the individual's private policy, if he or she had one.
- Reform of malpractice insurance and the small-business health insurance market.
- Creation of 250 more community and migrant health centers, and new programs to counter infant mortality.
- State experiments with some of the 10 broad health-system plans to see how well they work.

Robert Ball, former commissioner of Social Security and a leading adviser to congressional Democrats on the issue, sharply attacked the idea of undertaking demonstration projects that might stall national action instead of trying to work out a compromise on a large-scale systemic reform. He also criticized report language suggesting that the "window of opportunity" to fix the current system may be as long as seven to 10 years.

"I don't get any sense of urgency out of reading these recommendations," said Ball. Karen Ignani of the AFL-CIO said she favored having the council adopt some guidelines for national debate, such as endorsing the concept of a cap on the growth of health spending (without necessarily specifying what the cap should be).

Steelman agreed that the report language should sound more urgent, but said demonstration projects in various states would "start the ball rolling" toward exactly the kind of negotiations Ball wants. In addition, she said, it would be "absolutely criminal to hold back" on the various practical steps "to help people now" while there is no national consensus on a large-scale fix.

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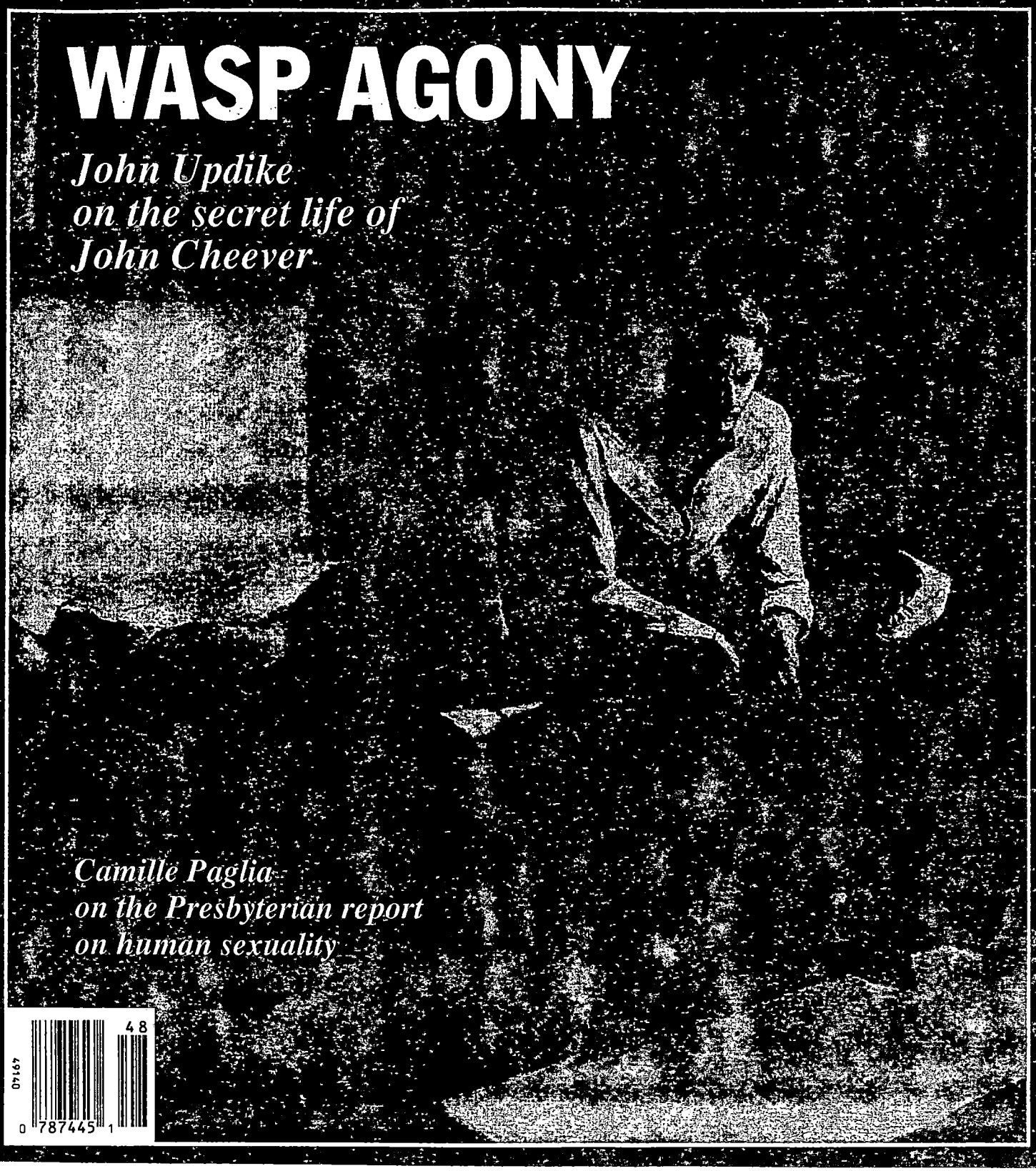
John Updike on the secret life of John Cheever

Camille Paglia on the Presbyterian report on human sexuality



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ism. *The Washington Post* would not have given credence to the stories in any other section of the paper. A cartoonist is not immune from such standards of journalistic veracity. Mr. Trudeau, whose cartoons are often brave and sassy, has this time gone too far. He should have left the Quayle story where he found it: in his file marked "Too Good to Check."

THOSE WERE THE DAYS:

September 5, 1966

Moyers 5. 12

LBJ

MEMORANDUM FOR MARVIN WATSON

FROM: Bill Moyers

This is to request a subscription in my name to The New Republic. I have found this magazine very useful in research work and, therefore, would like to receive a copy each month.

SNAP, CRACKLE, AND POP:

Women as Colleagues Can Turn Men Off
—*The Wall Street Journal*, October 29

At Work, Sexual Electricity Sparks Creativity
(same day, same paper)
(thanks to Keith Danish, Leonia, New Jersey)

OKLAHOMICIDE: A couple of papers have reported the bizarre case of Oklahoma death-row inmate Benjamin Brewer, who was nearly snuffed in his cell under the provisions of an obscure "frontier" law. The 80-year-old ordinance stipulates that the county sheriff has the authority to execute a condemned prisoner if no legal reason exists for further delay. The exact means of dispatching the prisoner, however, are left up to the lawman, and theoretically could include anything from shooting him in the head to reading long passages from *The Golden Bowl*. In Brewer's case, the sheriff was on his way to the penitentiary when a state appeals court stayed the execution. •

WHITE HOUSE WATCH

RUDE HEALTH

By Fred Barnes

Two years ago President Bush wandered into the Roosevelt Room as his aides were meeting with a group of conservatives. Columnist M. Stanton Evans was talking about soaring health care costs, and the president politely told Evans to continue. Evans warned that rising costs would cause rationing of health services. And this would allow Democrats to "demagogue for national health insurance unless the White House came up with market-based reform." Evans soon realized that neither Bush nor his aides had the slightest interest in the subject. "From the president's expression, body language, and lack of response to these remarks," Evans wrote later in *Human Events*, "I might as well have been discussing binomial theorem or the mineral heritage of Zimbabwe."

Bush is interested now. Even before the November 5 victory of Democratic Senator Harris Wofford in Pennsylvania, Bush had begun to take health care seriously. Last summer the issue was turned over to budget director Richard Darman, a sure signal something was up. The health care package Darman develops will be unveiled in the president's State of the Union address next January or soon thereafter. The problem is that Bush, like Republican Richard Thornburgh in the Pennsylvania Senate race, appears grudging and reactive—because he *is* grudging and reactive. "We don't do anything in a timely way," complains a White House official. "If we did, we'd have a domestic agenda." On the domestic side Bush never misses an opportunity to miss an opportunity.

Bush had a chance to seize the health insurance issue in 1989, 1990, and 1991. Several months into his administration, Secretary of Health and Human Services Louis Sullivan decided to explore the issue. He assigned then Deputy Secretary Constance Horner to the job. That fall the White House took over, putting Horner in charge of the administration's working group on health care. The group met monthly to develop options. Every six weeks Horner conferred with Darman, domestic policy adviser Roger Porter, and John Sununu, the White House chief of staff. But nothing happened. The White House wanted to contain the issue, not pursue it.

It took six weeks of lobbying by Horner and a handful of others to get three sentences in Bush's State of the Union speech in January 1990. The president said Sullivan would lead a "review of recommendations on the quality, accessibility, and cost of our nation's health care system. I am committed to bring the staggering costs of

health care under control." Of course the review Bush referred to had begun the year before, and Sullivan wasn't really in charge of it.

Why was the White House so reluctant? The reasons are chiefly political. Republicans, including the Bushies, regard health care as a Democratic issue. The judgment was also made that whoever went first with a health insurance package would be sharply criticized for it. "The goal was not to go first," says an official. Besides, if Bush went first, Democrats would quickly outbid his proposal. There was fear that Sullivan, whom the White House regarded as politically unreliable, might jump the gun by talking up a comprehensive insurance coverage. To avert that, the White House seized the issue. One other consideration nagged the White House: a fear of being attacked as callous for ignoring health care problems. The working group gave the White House something to cite, according to a Bush aide, as "visible activity on health care."

The politics of health care changed in 1991. By summer Darman had concluded that some program was likely to emerge from Congress in the early 1990s. This meant a Bush package had to be put together. Still, the health issue hardly gripped the White House. "I can't explain how unengaged people are until there's a live political necessity to get engaged," says an official. The Wofford win and a New Jersey referendum created the necessity. Wofford harped on national health insurance, insisting that if a criminal is guaranteed a lawyer then every sick person should have a right to a doctor. Wofford's election was hardly a mandate for national health insurance, but it confirmed public anxiety about health care coverage. So did the nonbinding referendum in New Jersey, which passed by a 4-to-1 margin in a Republican landslide. It called on Congress and the president to enact "a national health care program" with universal coverage and "minimal out-of-pocket expense to taxpayers."

The White House perked up, but didn't panic. "At the end of the day, people know the health care issue is dwarfed by the economy," says a senior White House official. "There's panic and paralysis here on the economy. There's concern and movement on health care." Bush is eager to avoid the fate of Thornburgh, who offered too little, too late on health care. Thornburgh ignored Wofford's health insurance theme until the closing days of the campaign. Then he zinged it as "untried, untested, radical, and costly." Thornburgh's own health care plan consisted of proposals to spur competition, hold down costs, and expand Medicaid.

Bush has two options. They aren't new. One plan, promoted by the Heritage Foundation, would require all Americans to have health insurance and create a refundable tax credit to help them pay for it. This was favored by Horner when she headed the working group (she's White House personnel chief now). At a Heritage forum in 1990 she said: "A health financing system that puts control into individual hands, and so broadens individual choice, is, I think, going to have considerable political appeal." Not enough, though.

Though Darman is intrigued by the Heritage plan, the White House has turned to the less-sweeping second option, incremental reforms to reduce the cost of health insurance and expand coverage. Horner's working group produced a ten-point package that includes tax incentives, deregulation of barriers to managed care, a cap on the tax exclusion for group benefits, a tax credit for each child, and expansion of Community Health Centers. The market-oriented package doesn't foreclose a Heritage-like insurance program later. "There's nothing in it that's antithetical to moving to Heritage over time," says a White House aide. It addresses what Bush aides think is the real source of public anxiety about health coverage: not lack of national health insurance, but gaps in the current system. The package doesn't provide insurance for everyone, but it makes it easier for small businesses, individuals, folks out of work or in between jobs, and the poor to buy insurance. My guess is that Bush will propose something like the ten-point plan next year, presenting it as a giant step toward his freshly minted vision of universal, high-quality health care.

It might work. Bush doesn't deserve to escape trouble after dawdling so long. But politics is unfair. A presidential proposal, tardily but relentlessly advocated, may prevail. The Bush plan has an added political plus. It leaves Bush plenty of what GOP consultant Mike Murphy calls "shooting room." He's free to attack Democratic plans as socialized medicine, which will require higher taxes and more Washington bureaucracy. Thornburgh tried that, but too late. Bush can start early. Roger Ailes, get ready. •

THE PRESS

MARIO'S CALLING

By Jacob Weisberg

Dave Hepp decided to try the direct approach. At the outset of "Stateline," his live, viewer call-in show on New York public television, he asked Mario Cuomo whether he was running for president. The governor said he had been thinking about it, was assembling facts, and would complete the process of deciding as soon as possible.

Hepp pressed the question. "I've talked to a lot of civilians—not insiders, not politicians—who tell me that they're angry about this, tell me that they're frustrated, tell me that they think you're kind of . . . "

"About what? Angry about what?" Cuomo snapped.

"They think you're playing a game with them."

"See, I don't believe you, actually, Dave."

"Actually I have talked to a lot people about this."